



Medicaid Enterprise  
Department of Human Services

For Human Services use only:  
**General Letter No. 8-AP-286**  
Employees' Manual, Title 8  
Medicaid Appendix

May 9, 2008

## **RURAL HEALTH CLINIC TRANSMITTAL NO. 08-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Rural Health Clinic***, Title Page, revised; Table of Contents, new; Chapter III, *Provider-Specific Policies*, Title Page, new; Table of Contents, pages 1 and 2, new; pages 1 through 76, new; and the following forms:

RC-0080	<i>Screening Components by Age</i> , new
470-2942	<i>Medicaid Prenatal Risk Assessment</i> , revised
470-0836	<i>Certification Regarding Abortion</i> , revised
470-0835	<i>Consent for Sterilization</i> , revised
470-0835S	<i>Consent for Sterilization (Spanish)</i> , revised
470-3495	<i>Managed Care Wraparound Payment Request</i> , revised
CMS-1500	<i>Health Insurance Claim Form</i> , revised
470-3969	<i>Claim Attachment Control</i> , revised
	<i>Remittance Advice</i> , revised

### **Summary**

Chapters on coverage and limitations and on billing and payment for rural health clinics are combined and revised to reflect the implementation of the Iowa Medicaid Enterprise and the reorganization of the Medicaid "All Providers" manual chapters.

Within the manual, the form samples have been removed from the numbered pages and connected to the on-line manual through hypertext links. This will make the chapters quicker to load on line and easier to read and update.

This release:

- ◆ Revises descriptions of the EPSDT screening components to reflect current standards.
- ◆ Removes form 470-3165, *Child Mental Health Screen*. A variety of screening tools can be used in primary care settings to discover indications of mental health problems.
- ◆ Revises the prenatal risk assessment and abortion forms.
- ◆ Updates the claim form and claim attachment form.

### **Date Effective**

Upon receipt.

## Material Superseded

Remove the entire Chapter E and Chapter F from ***Rural Health Clinic Manual*** and destroy them. This includes the following:

<u>Page</u>	<u>Date</u>
Contents (p. 4)	November 1, 2001
Contents (p. 5)	July 1, 2003
Contents (p. 6)	November 1, 2001
<b>Chapter E</b>	
1-3	August 1, 1995
4	January 1, 1997
5	March 1, 1999
6, 6a, 7	July 1, 2003
8	November 1, 2001
9, 10(470-2942)	5/03
11-16, 16a, 16b	November 1, 2001
16c, 16d (470-0836)	1/99
16e-16h	February 1, 1999
16i, 16j (470-0835)	7/03
16k, 16l, 17	February 1, 1999
18	July 1, 2003
19-22	August 1, 1995
23-25 (470-3165)	8/95
26-28	January 1, 1997
29-31	August 1, 1995
32-34, 37	July 1, 2003
38-40	May 1, 1997
41, 42	July 1, 2003
43	November 1, 2001
44	July 1, 2003
45, 46	November 1, 2001
47, 48	November 1, 1998
49-53	January 1, 1997
54	July 1, 2003
55	January 1, 1997
56	August 1, 1995
57-70	July 1, 2003
<b>Chapter F</b>	
1, 2	November 1, 1998
3 (470-0829)	4/98
5, 6	November 1, 1998
6a	July 1, 2003
6b (470-3970)	7-03
7-9	November 1, 1998
10	July 1, 2003
11-14	November 1, 1998
15, 16 (HFCA-1500)	12-90
16a	July 1, 2003
16b (470-3969)	7-03

17, 18	November 1, 1998
19	06/12/97
21-25	November 1, 1998
27 (470-3495)	6/03
28	July 1, 2003
29 (470-3744)	10/02
31 (470-0040)	10/02

### **Additional Information**

The updated provider manual containing the revised pages can be found at:

**[www.dhs.state.ia.us/policyanalysis](http://www.dhs.state.ia.us/policyanalysis)**

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise  
Provider Services  
PO Box 36450  
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.


If any portion of this manual is not clear, please direct your inquiries to Iowa Medicaid Enterprise Provider Services Unit.



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Iowa Department of Human Services

# **Rural Health Clinic Provider Manual**

 Medicaid Enterprise Department of Human Services	Provider <b>Rural Health Clinic</b>	Page 1
		Date May 1, 2008

## TABLE OF CONTENTS

### [Chapter I. General Program Policies](#)

### [Chapter II. Member Eligibility](#)

### [Chapter III. Provider-Specific Policies](#)


### [Appendix](#)



**Medicaid Enterprise**

Iowa Department of Human Services

## **III. Provider-Specific Policies**

 Medicaid Enterprise Department of Human Services	Provider  <b>Rural Health Clinic</b>	Page  1
		Date  May 1, 2008

## TABLE OF CONTENTS

Page

<b>CHAPTER III. PROVIDER-SPECIFIC POLICIES.....</b>	<b>1</b>
A. ELIGIBILITY OF RURAL HEALTH CLINICS.....	1
B. COVERAGE OF SERVICES.....	1
1. Physician Services.....	1
2. Services of Other Practitioners.....	2
3. Care for Kids Screening Examinations.....	2
4. Immunizations .....	3
5. Nutritional Counseling .....	3
6. Family Planning Services.....	4
7. Obstetrical Services .....	5
a. Form 470-2942, Medicaid Prenatal Risk Assessment .....	5
b. How to Use the Risk Assessment Form.....	5
c. Enhanced Prenatal Services.....	7
8. Surgery.....	10
a. Abortions.....	10
b. Sterilizations.....	14
c. Hysterectomies .....	18
9. Transportation.....	19
C. CONTENT OF SCREENING EXAMINATION.....	20
1. History and Guidance .....	21
a. Comprehensive Health and Developmental History .....	21
b. Developmental Screening .....	22
c. Mental Health Assessment .....	24
d. Health Education/Anticipatory Guidance .....	26
2. Physical Examination.....	32
a. Growth Measurements.....	32
b. Head Circumference.....	35
c. Blood Pressure .....	35
d. Oral Health Screening .....	38
3. Laboratory Tests.....	39
a. Hemoglobin and Hematocrit .....	39
b. Urinalysis .....	41
c. Newborn Screening.....	41
d. Hemoglobinopathy Screening .....	42



Medicaid Enterprise  
Department of Human Services

Provider

**Rural Health Clinic**

Page

2


Date

May 1, 2008

Page

e.	Tuberculin Testing .....	42
f.	Lead Testing .....	42
g.	Cervical Papanicolaou (PAP) Smear .....	50
h.	Gonorrhea Test .....	51
i.	Chlamydia Test .....	51
4.	Other Services .....	51
a.	Immunization.....	51
b.	Nutritional Status .....	52
c.	Vision .....	56
d.	Hearing.....	59
D.	BASIS OF PAYMENT FOR RURAL HEALTH CLINIC SERVICES .....	61
1.	Initial Cost Report.....	61
2.	Annual Cost Report .....	62
3.	Form 470-3495, Managed Care Wraparound Payment Request.....	62
E.	PROCEDURE CODES .....	64
F.	CMS-1500 CLAIM FORM .....	64
1.	Instructions for Completing the Claim Form .....	64
2.	Claim Attachment Control, Form 470-3969 .....	72
G.	REMITTANCE ADVICE AND FIELD DESCRIPTIONS .....	73
1.	Remittance Advice Explanation .....	73
2.	Remittance Advice Sample and Field Descriptions.....	74



 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 1
		Date May 1, 2008

## CHAPTER III. PROVIDER-SPECIFIC POLICIES

### A. ELIGIBILITY OF RURAL HEALTH CLINICS

Rural health clinics are eligible to participate in Iowa Medicaid providing they are certified eligible to participate in the Medicare program. Clinics located in other states are also eligible to participate, providing they are Medicare-certified in that state.

### B. COVERAGE OF SERVICES

In addition to the services listed below, additional ambulatory services within the scope of the Medicaid program are reimbursable as rural health clinic services. (See [COVERAGE OF MEDICAL AND HEALTH SERVICES](#) in Chapter I.)


#### 1. Physician Services

Services performed by a physician at the clinic are covered as rural health clinic services, and are reimbursable only to the clinic. Covered services performed by a physician outside the clinic are also covered rural health clinic services if the clinic compensates the physician for the services.

Services and supplies incident to a physician's professional services are covered and reimbursable as rural health clinic services if the service or supply is:

- ◆ Of the type commonly furnished in a physician's office, and
- ◆ Rendered either without charge or included in the rural health clinic's bill, and
- ◆ Furnished as an incidental although integral part of a physician's professional services, and
- ◆ Furnished under the direct personal supervision of a physician, and

In the case of drugs and biologicals furnished incident to the physician's professional service, only those that cannot be self-administered are covered.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	2 <hr/> Date May 1, 2008

## 2. Services of Other Practitioners

Services furnished by physician assistants and nurse practitioners, including nurse midwives and specialized nurse practitioners, are covered whether or not the clinic is under the full-time direction of a physician. Services and supplies which are furnished incident to a nurse practitioner's or physician assistant's services in the clinic must be of a type that:

- ◆ Would be covered if furnished as incident to a physician service,
- ◆ Is commonly furnished in physician offices, and
- ◆ Is commonly rendered without charge or included in the clinic's bill. To be covered under this provision, the services must be furnished by an employee of the clinic and under the direct supervision of a nurse practitioner, physician assistant, or physician.

Coverage is also provided for visiting nurse service if the rural health clinic is located in an area where there is a shortage of home health service (as determined by Medicare).

In such cases, part-time or intermittent nursing services provided by a registered nurse or licensed practical nurse are covered if they are furnished under a written plan of treatment that is established and reviewed in accordance with the Medicare regulations for home health services.

## 3. Care for Kids Screening Examinations

Rural health clinics will be paid for health screening examinations for Medicaid-eligible persons who are under 21 years of age.

The recommended schedule for health, vision, and hearing screening is as follows:

<u>Child's Age</u>	<u>Number of Screenings Recommended</u>	<u>Recommended Ages for Screening</u>
0 to 12 months	7	2-3 days,* 1, 2, 4, 6, 9, and 12 months
13 to 24 months	3	15, 18, and 24 months
3 to 6 years	4	3, 4, 5, and 6 years
7 to 20 years	7	8, 10, 12, 14, 16, 18, and 20 years

\* For newborns discharged in 24 hours or less after delivery.

Iowa Department of Human Services

# Screening Components by Age

Age	Infancy							Early Childhood					Late Childhood					Adolescence			
	2-3 <sup>1</sup> days	by 1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	6 yr	8 yr	10 yr	12 yr	14 yr	16 yr	18 yr	20+ yr
<b>HISTORY</b> Initial/Internal	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
<b>PHYSICAL EXAM</b>	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
<b>MEASUREMENTS</b> Height/Weight Head Circumference Blood Pressure	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
<b>NUTRITION ASSESS/EDUCATION</b>	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
<b>ORAL HEALTH <sup>2</sup></b> Oral Health Assessment Dental Referral	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
<b>SENSORY SCREENING</b> Vision Hearing	S O	S S	S S	S S	S S	S S	S S	S S	S S	S S	O O	O O	O O	O S	O S	O S	O O	O S	S S	O O	O S
<b>DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT <sup>3</sup></b>	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★	★
<b>IMMUNIZATION <sup>4</sup></b>	★		★	★	★			★	★				★	★	★	★		★			
<b>PROCEDURES</b> Hgb/Hct Urinalysis Metabolic screening <sup>5</sup>	★	★																	★		

**KEY:** ★ To be performed  
S Subjective, by history

★ Perform test once during indicated time period  
O Objective, by a standard testing method

*Continued on next page.*

<b>HEMOGLOBINOPATHY</b>	Only once (newborn screen) and offered to adolescents at risk.
<b>TUBERCULIN TEST</b>	For high-risk groups, annual testing is recommended. These are household members of persons with tuberculosis or others at risk for close contact with the disease: recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders.
<b>LEAD</b>	Starting at 12 months, assess risk for high dose exposure.
<b>GYNECOLOGIC TESTING</b>	Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history.
<b>STD</b>	When appropriate. (People with a history and risk factors for sexually transmitted diseases should be tested for chlamydia and gonorrhea.)
<b>ANTICIPATORY GUIDANCE</b>	Performed every visit.

<sup>1</sup> For newborns discharged in 24 hours or less after delivery.

<sup>2</sup> The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.

<sup>3</sup> By history and appropriate physical examination, if suspicious, by specific objective developmental testing.

<sup>4</sup> An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.

<sup>5</sup> The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia.



The periodicity schedule provides a minimum basis for follow-up examinations at critical points in a child's life. Families who accept screening will receive a notice that screening is due 60 days before the recommended ages for screening. New eligibles will receive a notice that screening is due immediately and then notified according to the recommended ages.

If children or youth come under care for the first time at any point on the schedule, or if any of the items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest time.

To view RC-0080, *Screening Components by Age*, on line, click [here](#). These recommendations for preventive health care of children and youth represent a guide for the care of well children who:

- ◆ Receive competent parenting,
- ◆ Have not manifested any important health problems, and
- ◆ Are growing and developing satisfactorily.

Other circumstances may indicate the need for additional visits or procedures.

Interperiodic screening, diagnosis, and treatment allow the flexibility necessary to strengthen the preventative nature of the program. Interperiodic screens may be obtained:

- ◆ As required by foster care or educational standards and
- ◆ When requested for a child.

#### **4. Immunizations**

Providers must provide immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are listed on the Iowa Department of Public Health web site at:

[www.idph.state.ia.us/adper/vaccines\\_for\\_children.asp](http://www.idph.state.ia.us/adper/vaccines_for_children.asp)

#### **5. Nutritional Counseling**

Nutritional counseling services provided by licensed dietitians for members aged 20 and under are covered when a nutritional problem or condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.



Such medical conditions may include:

- ◆ **Inadequate or excessive growth.** Examples include failure to thrive, undesired weight loss, underweight, excessive increase in weight relative to linear growth, and major changes in weight-to-height percentile or BMI for age.
- ◆ **Inadequate dietary intake.** Examples include formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite.
- ◆ **Infant feeding problems.** Examples include poor suck or swallow, breastfeeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited information or skills of caregiver.
- ◆ **Chronic disease requiring nutritional intervention.** Examples include congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, diabetes, and gastrointestinal disease.
- ◆ **Medical conditions requiring nutritional intervention.** Examples include iron deficiency anemia, high serum lead level, hyperlipidemia, familial hyperlipidemia, and pregnancy.
- ◆ **Developmental disability.** Examples include increased risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, and tube feedings.
- ◆ **Psychosocial factors,** such as behaviors suggesting an eating disorder.

This is not an all-inclusive list. Other diagnoses may be appropriate.

## 6. Family Planning Services

Family planning services include the following:

- ◆ Examination and tests necessary before prescribing family planning services.
- ◆ Contraceptive services.
- ◆ Family planning supplies, such as an IUD, diaphragm, or basal thermometer.

Direct family planning services receive additional federal funds. Therefore, it is important to indicate family planning services on the claim form by adding the modifier "FP" after the procedure code.

Iowa Department of Human Services  
**MEDICAID PRENATAL RISK ASSESSMENT**

Primary provider name	Provider phone number	Date
Client name	Phone number	Client date of birth
Address		Medicaid ID number

Gestational age at initial assessment:	Weeks	Date	Gestational age at rescreen:	Weeks	Date
--	-------	------	------------------------------	-------	------

**Instructions:** Write the score that applies to each risk factor. (\* For risk factor definitions and nutrition screen, see back.)

Risk Factor/Value	A Score Initial	Risk Factor Current Pregnancy/Value	B1 Initial OB	B2 Rescreen 28 wks+
Maternal age 20-40 = 0      16-19 or >40 = 4      ≤ 15 = 10		Bacteriuria,* chlamydia, GC this pregnancy no = 0      yes = 3		
Education GED or 12 = 0      ≤ 11 = 2      ≤ 8 = 4		Pyelonephritis * no = 0      yes = 5		
Marital status married = 0      single, divorced, separated = 2		Fibroids no = 0      yes = 3		
Height >5 feet = 0      ≤ 5 feet = 3		Presenting part engaged < 36 weeks no = 0      yes = 3		
Prepregnancy weight low (BMI < 19.8) = 2      obese (BMI > 29.0) = 2		Uterine bleeding ≥ 12 weeks * no = 0      yes = 4		
AB 1st trimester * < 3 = 0      ≥ 3 = 1		Cervical length < 1 cm < 34 weeks no = 0      yes = 4		
AB 2nd trimester * none = 0      1 = 5      ≥ 2 = 10		Dilation ≥ 1 cm * no = 0      yes = 4		
Race white = 0      black = 2      other = 1		Uterine irritability * ≤ 34 weeks no = 0      yes = 4		
Cone biopsy/LEEP no = 0      yes = 3		Placenta previa at < 30 weeks no = 0      yes = 4		
Uterine anomaly * no = 0      yes = 10		Oligohydramnios no = 0      yes = 10		
Previous SGA baby no = 0      yes = 10		Polyhydramnios no = 0      yes = 10		
Hx preterm labor * or preterm delivery no = 0      yes = number x 10		Multiple pregnancy no = 0      yes = 10+		
Bleeding gums/never been to dentist no = 0      yes = 5		Surgery (abdominal * ≥ 18 weeks or cerclage) no = 0      yes = 10		
Cigarette use/day 1 cig – 1/2 ppd = 1      > 1/2 ppd = 4		Depression ♦ Over the past 2 weeks have you ever felt down, depressed or hopeless? ♦ Over the past 2 weeks have you felt little interest or pleasure in doing things? (to either)      no = 0      yes = 10		
Illicit drug use * (this pregnancy) no = 0      yes = 5				
Alcohol use * (this pregnancy) no = 0      yes = 2				
Initial prenatal visit * < 16 wks = 0      > 16 wks = 2		Weight gain at 22 weeks ≥ 7 lb. = 0      < 7 lb. = 2		
Poor social situation * no = 0      yes = 5		Weight loss < 5 lb. = 0      ≥ 5 lb. = 3		
Children ≤ 5 years at home 0 or 1 = 0      ≥ 2 = 2		Urine protein 0/trace = 0      1+ = 2      > 1+ = 5		
Employment * none = 0    outside school/work = 1    heavy work = 3		Hypertension * or HTN medications no = 0      yes = 10		
Last pregnancy within 1 year of present pregnancy no = 0      yes = 1		Hemoglobin      Hematocrit < 11 = 3      < 33 = 3		
<b>Subtotal A</b>		<b>Subtotal B1 and B2</b>		
Other: _____ Additional risk factors indicating need for enhanced services. (See back for examples.) Points need not total 10.		Subtotal A		
		Subtotal B1	+	Subtotal B2
		Total 1st OB		Total 28 weeks screen

**Total score of 10 points or more = high risk for preterm delivery.** Check all enhanced antepartum management services that apply and indicate who will be the primary provider of each service.

- |  |   |
|--|---|
| <input type="checkbox"/> Care coordination   | <input type="checkbox"/> Nutrition counseling   |
| <input type="checkbox"/> Health education    | <input type="checkbox"/> Home visit             |
| <input type="checkbox"/> Psychosocial        | <input type="checkbox"/> Oral health            |
| <input type="checkbox"/> High risk follow-up | <input type="checkbox"/> Medical transportation |


Signature of primary provider	Date	Client signature: Release of information	Date
Date of referral for WIC services:		(State WIC Office – 1-800-532-1579)	

Risk Factor Definition
<b>AB 1st trimester:</b> More than three spontaneous or induced abortions at less than 13 weeks gestation. (Do not include ectopic pregnancies.)
<b>AB 2nd trimester:</b> Spontaneous or induced abortion between 12 and 19 weeks gestation.
<b>Uterine anomaly:</b> Bicornate, T-shaped, or septate uterus, etc.
<b>Dental visit:</b> Routine preventive dental care; not visit for emergency extraction, mouth trauma.
<b>DES exposure:</b> Exposure to diethylstilbesterol in utero. Patient who has anomalies associated with diethylstilbesterol receives points for this item and uterine anomaly.
<b>Hx PTL:</b> Spontaneous preterm labor during any previous pregnancies (whether or not resulting in preterm birth) or preterm delivery.
<b>Hx pyelonephritis:</b> One or more episodes of pyelonephritis in past medical history.
<b>Illicit drug use:</b> Any street drug use during this pregnancy, e.g., speed, marijuana, cocaine, heroin (includes methadone), huffing, or the recreational use of Rx or OTC drugs.
<b>Alcohol use:</b> Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking.
<b>Initial prenatal visit:</b> First prenatal visit at or after 16 weeks gestation.
<b>Poor social situation:</b> Personal or family history of abuse, incarceration, homelessness, unstable housing, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support system, low self esteem.
<b>Employment:</b> Light work = part time or sedentary work or school Heavy work = work involving strenuous physical effort, standing, or continuous nervous tension, such as, nurses, sales staff, cleaning staff, baby-sitters, laborers
<b>Bacteriuria:</b> Any symptomatic or asymptomatic urinary tract infection, i.e., 100,000 colonies in urinalysis.
<b>Pyelonephritis:</b> Diagnosed pyelonephritis in the current pregnancy. (Give points for pyelonephritis only, not both pyelonephritis and bacteriuria.)
<b>Bleeding after 12th week:</b> Vaginal bleeding or spotting after 12 weeks of gestation of any amount, duration, or frequency which is not obviously due to cervical contact.
<b>Dilation (Internal os):</b> Cervical dilation of the internal os of one cm or more at 34 weeks gestation.
<b>Uterine irritability:</b> Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks.
<b>Surgery:</b> Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy.
<b>Hypertension:</b> Two measurements showing an increase of systolic pressure of 30 mgHg above baseline, an increase in diastolic pressure of 15 mgHg above baseline, or both.

Nutritional Risk Factor Assessment and Definitions
<b>Instructions:</b> Check nutrition counseling if any of the factors below indicate nutritional risk.
<b>Anemia:</b> Hgb < 11 or Hct < 33 (weeks 1-13 and weeks 27-40+) Hgb < 10.5 or Hct < 32 (weeks 14-26)
<b>Inappropriate nutrition practices:</b>
<ul style="list-style-type: none"> <li>◆ Consuming potentially harmful dietary supplements (includes excessive doses and those that may be toxic or harmful in other ways)</li> <li>◆ Consumes diet very low in calories or essential nutrients (includes vegan diet defined as consuming only fruits, vegetables, and grains; macrobiotic diet; food faddism; and impaired calorie intake or nutrient absorption following bariatric surgery)</li> <li>◆ Pica</li> <li>◆ Inadequate iron supplementation (&lt; 30 mg/day)</li> <li>◆ Consuming foods potentially contaminated with pathogenic bacteria (raw seafood, meat, poultry, and eggs or any foods containing these products; raw sprouts; undercooked meat, poultry, and eggs; unpasteurized milk or foods containing it; soft cheeses such as feta, Brie, Camembert, blue-veined and Mexican-style cheese; unpasteurized fruit or vegetable juices; and hot dogs and luncheon meats unless reheated until steaming hot)</li> </ul>

Examples of additional risk factors:	
Medical	<ul style="list-style-type: none"> <li>◆ Autoimmune disease</li> <li>◆ Current eating disorder, fasting, skipping meals</li> <li>◆ Diabetes</li> <li>◆ Febrile illness</li> <li>◆ Gestational diabetes</li> <li>◆ Heart disease</li> <li>◆ History of gastric bypass</li> <li>◆ HIV</li> <li>◆ Hyperemesis</li> <li>◆ Psychiatric disorder</li> <li>◆ Renal disease</li> <li>◆ Seizure disorders</li> <li>◆ Thyroid disease</li> <li>◆ Type I diabetes</li> </ul>
OB History	<ul style="list-style-type: none"> <li>◆ Caesarean section</li> <li>◆ Infertility</li> <li>◆ Perinatal loss</li> </ul>
Psychosocial	<ul style="list-style-type: none"> <li>◆ Ambivalent, denying, or rejecting of this pregnancy</li> <li>◆ Child care stress</li> <li>◆ Cultural or communication barriers</li> <li>◆ History of mental illness</li> <li>◆ Not compliant with visit or healthy pregnancy behaviors (or not expected to be compliant without additional intervention)</li> <li>◆ Teen pregnancy</li> </ul>



 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	5 <hr/> Date May 1, 2008

## 7. Obstetrical Services

### a. Form 470-2942, Medicaid Prenatal Risk Assessment

All pregnant Medicaid members must have a determination of risk using form 470-2942, *Medicaid Prenatal Risk Assessment*, twice during pregnancy. To view a sample of this form on line, click [here](#).

The *Medicaid Prenatal Risk Assessment* was developed jointly by the Iowa Department of Human Services and the Iowa Department of Public Health. It was designed to help the clinician determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

The first assessment shall be done at the member's initial entry into care. For the low-risk patient, the second assessment shall be done:

- ◆ At approximately 28 weeks, or
- ◆ When you determine there is an increase in the member's risk status.

When the risk assessment reflects a high-risk pregnancy:

- ◆ Inform the member, and
- ◆ Provide a referral for enhanced services.

Give a copy of the *Medicaid Prenatal Risk Assessment* to the enhanced services agency. Keep a copy in the patient's medical records.

### b. How to Use the Risk Assessment Form

The left side of form 470-2942 includes risk factors relating to medical, historical, environmental, or situational factors. A description of many of the risk factors is included on the back of the form. Included are AB first trimester, AB second trimester, uterine anomaly, HX pyelonephritis, illicit drug use, and poor social situation.

Give cigarette smoking a point value if the member smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."



Indicate the risk factor "Last birth within 1 year" when the member has been pregnant within one year of the beginning of the present pregnancy.

The right side of the form includes risk factors related to the current pregnancy. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the middle or last trimester. For this reason, these risk factors are assessed twice during the pregnancy.

Depression has an impact on the development and management of pregnancy related complications. Untreated depression has been associated with unfavorable health behaviors in pregnancy and subsequent fetal growth restrictions, preterm delivery, placental abruption, or newborn irritability.

Using the following two questions to screen for depression may be as effective as more lengthy tools.

- ◆ Over the past two weeks, have you ever felt down, depressed, or hopeless?
- ◆ Over the past two weeks, have you felt little interest or pleasure in doing things?

A positive response to both questions suggests the need for further evaluation. A positive response to one of these questions is sufficient to provide services for a high-risk pregnancy.

(Source: *Psychosocial Risk Factors: Prenatal Screening and Interventions*, ACOG Committee Opinion No 343, American College of Obstetricians and Gynecologists, Obstet Gynecol 2006, 108:469-77.)

Use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These common examples only and are not meant to be a comprehensive list.

To determine the patient's risk status during the current pregnancy, add the total score value on the left side and either the B1 column (score value at the initial visit) or the B2 column (score value at a visit between 24 and 28 weeks gestation) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.



### c. **Enhanced Prenatal Services**

The services included in the Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, Caring for the Future: The Content of Prenatal Care.

National studies have shown that low-income women who receive these enhanced services along with medical prenatal care have better birth outcomes. This package of services is aimed at promoting better birth outcomes for Medicaid-eligible pregnant women in Iowa.

The primary medical care provider will continue to provide the medical care. Maternal health centers that provide enhanced services work with clinicians to provide enhanced services for higher risk pregnant women. This process allows members who are determined high risk to access additional services that Medicaid does not provide under other circumstances.

Enhanced services may be provided by physicians, registered nurses, licensed nutritionists, and bachelor-degree social workers or other licensed mental health professionals. Maternal health centers are one provider of enhanced services. Enhanced services are as follows:

#### **(1) Care Coordination**

A registered nurse or social worker shall provide the coordination of comprehensive prenatal services. Coordination shall include:

- ◆ Developing an individual plan of care based on the member's needs.
- ◆ Ensuring that the member receives all appropriate components: medical, education, nutrition, psychosocial, and postpartum home visit.
- ◆ Risk tracking.

#### **(2) Education**

A registered nurse shall provide education services. Education shall include as appropriate, education about high-risk medical conditions, including:



- ◆ Conditions related to pregnancy, such as PIH, preterm labor, vaginal bleeding, diabetes (gestational and regular), chronic urinary conditions, and genetic disorders.
- ◆ Chronic conditions, such as diabetes, epilepsy, cardiac disease, sickle-cell disease, and hypertension.
- ◆ Other conditions, such as HIV, hepatitis, and STDs.
- ◆ High-risk sexual behavior.
- ◆ Smoking cessation.
- ◆ Alcohol usage.
- ◆ Drug usage.
- ◆ Environmental and occupational hazards.

Education services may include referral to psychosocial services for high-risk parenting issues, high-risk home situations, stress management, communication skills and resources, and self-esteem.

### **(3) Nutrition**

A licensed dietitian shall provide nutrition services. Nutrition assessment and counseling shall include:

- ◆ Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
- ◆ Ongoing nutritional assessment (at least once every trimester) as evidenced by dietary information, adequacy of weight gain, measures to assess uterine and fetal growth, laboratory data, and clinical data.
- ◆ Development of an individualized nutritional care plan.
- ◆ Referral to food assistance programs, if indicated.
- ◆ Nutritional intervention:
  - Nutritional requirements of pregnancy as linked to fetal growth and development.
  - Recommended dietary allowances for pregnancy.
  - Appropriate weight gain.



- Vitamin and iron supplements.
- Information to make an informed infant feeding decision.
- Education to prepare for the proposed feeding method and the support services available to her.
- Infant nutritional needs and feeding practices.

#### **(4) Psychosocial Services**


A social worker or other licensed mental health professional shall provide psychosocial services. Services shall include:

- ♦ A psychosocial assessment including a needs assessment, a profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
- ♦ A profile of the client's family composition, patterns of functioning and support system.
- ♦ An assessment-based plan of care.
- ♦ Risk tracking.
- ♦ Counseling and anticipatory guidance as appropriate.
- ♦ Referral and follow-up services.

#### **(5) Postpartum Home Visit**

A registered nurse shall do a follow-up home visit. The visit should ideally be provided in the first week postpartum but no later than two weeks postpartum. The visit shall include:

- ♦ Assessment of mother's health status.
- ♦ Physical and emotional changes postpartum, such as relationships, sexual changes, stress, nutritional needs, and physical activity.
- ♦ Family planning.
- ♦ Parenting skills, such as nurturing, meeting infant needs, and bonding.
- ♦ Assessment of infant health.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 10
		Date May 1, 2008

- ◆ Infant care, including:
  - Feeding and nutritional needs.
  - Breast feeding support.
  - Recognition of illness.
  - Accident prevention.
  - Immunizations and well child care.
- ◆ Grief support for unhealthy outcome.
- ◆ Parenting a sick or preterm infant.
- ◆ Identification and referral to community resources as needed.

## 8. Surgery

### a. Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

- ◆ The attending physician certifies in writing on the basis of professional judgment that the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- ◆ The attending physician certifies in writing on the basis of professional judgment that the life of the pregnant woman would be endangered if the fetus was carried to term.
- ◆ An official of a law enforcement agency or a public or private health agency (including a family physician), certifies in writing that:
  - The pregnancy is the result of rape that was reported to the agency within 45 days of the date of the incident, and
  - The report contains the name, address, and signature of the person making it.
- ◆ An official of a law enforcement agency or a public or private health agency (including a family physician) certifies in writing that:
  - The pregnancy resulted from incest that was reported to the agency within 150 days of the incident, and
  - The report contains the name, address, and signature of the person making it.
- ◆ Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

## CERTIFICATION REGARDING ABORTION

### I. CERTIFICATION BY PHYSICIAN

#### CERTIFY TO ONE OF THE FOLLOWING:

I certify that on the basis of my professional judgment:

☐ **Life of the Mother.** \_\_\_\_\_ suffers from  
(Name and address of the mother)  
a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.

☐ **Fetus Deformed.** The fetus carried by \_\_\_\_\_  
(Name and address of the mother)  
is physically deformed, mentally deficient, or afflicted with a congenital illness based on: \_\_\_\_\_  
\_\_\_\_\_  
(Medical indications)

\_\_\_\_\_  
Signature of attending provider

\_\_\_\_\_  
Date

### II. CERTIFICATION BY AGENCY

#### 1. Rape

I, \_\_\_\_\_, of \_\_\_\_\_ received  
(Name of Official) (Name of Agency)  
a signed form from \_\_\_\_\_  
(Name and address of person reporting)  
stating that \_\_\_\_\_ was the victim of an incident of rape.  
(Name and address of the mother)

The incident took place on \_\_\_\_\_ and the incident was reported on \_\_\_\_\_  
(Date) (Date)

The report included the name, address and signature of the person making the report.

\_\_\_\_\_  
Signature of official of law enforcement, public or private health agency which may include a family physician

\_\_\_\_\_  
Date

#### 2. Incest

I, \_\_\_\_\_, of \_\_\_\_\_ received  
(Name of Official) (Name of Agency)  
a signed form from \_\_\_\_\_  
(Name and address of person reporting)  
stating that \_\_\_\_\_ was the victim of an incest incident.  
(Name and address of the mother)

The incident took place on \_\_\_\_\_ and the incident was reported on \_\_\_\_\_  
(Date) (Date)

The report included the name, address and signature of the person making the report.

\_\_\_\_\_  
Signature of official of law enforcement, public or private health agency which may include a family physician

\_\_\_\_\_  
Date

## CONDITIONS FOR MEDICAID PAYMENT FOR ABORTIONS


Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

1. Where the attending physician certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is only available in these situations if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.
2. Where the attending physician certifies in writing on the basis of his/her professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
3. If the pregnancy is the result of rape, and that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.
4. If the pregnancy is the result of incest and that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency or physician must so certify in writing.

A copy of the form, *Certification Regarding Abortion* (470-0836), must be attached to any Medicaid claim associated with the abortion. **Payment will not be made to the attending physician or to other physicians assisting in the abortion or to the hospital if the required certification is not submitted by the provider with the claim for payment.** It is the responsibility of the attending physician to make a copy of the certification available to the hospital and other physicians billing for the services associated with the abortion.

In the case of pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as set forth above. The recipient, someone acting in her behalf, or the attending physician is responsible for obtaining the necessary certification from the agency involved. The form, *Certification Regarding Abortion* (470-0836), is to be used for this purpose. It is also the responsibility of the physician to make a copy of the certification available to the hospital and any other physician billing for the service. This will facilitate payment to the hospitals and other physicians on abortion claims.



 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 11
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Date May 1, 2008

Federal funding is available to terminate a pregnancy

- ◆ That was the result of rape or incest;
- ◆ Of a woman who suffers from a physical disorder, injury, or illness, including a physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

A copy of form 470-0836, *Certification Regarding Abortion*, must be attached to the claim if payment is to be made for an abortion. (See [Certification Regarding Abortion, Form 470-0836](#), for more information.)

All abortion claims must be billed with the appropriate ICD-9 abortion diagnosis and CPT abortion procedure code on the CMS-1500 claim. Documentation identifying the reason for the abortion must also be attached to the claim. This includes, but is not limited to:


- ◆ The operative report
- ◆ Pathology report
- ◆ Laboratory report
- ◆ Ultrasound report
- ◆ Physician's progress notes
- ◆ Other documents that support the diagnosis identified on the claim

#### **(1) Certification Regarding Abortion, Form 470-0836**

Payment cannot be made either to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if form 470-0836, *Certification Regarding Abortion*, is not submitted with the claim for payment. To view a sample of this form on line, click [here](#).

It is the responsibility of the physician to make a copy of form 470-0836 available to the hospital, other physicians, anesthetists, certified registered nurse anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other physicians on abortion claims.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, a public or private health agency, or the family physician is required as set forth above.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 12
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Date May 1, 2008

It is the responsibility of the member, someone acting in her behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.

## **(2) Coverage of Mifepristone (Mifeprex or RU-486)**


Mifepristone (Mifeprex or RU-486), may be used in combination with Misoprostol to terminate a pregnancy. All of the stated policy for coverage of abortions (coverage criteria, form 470-0836, and medical records) apply to the use of Mifepristone.

## **(3) Services Associated With Noncovered Abortions**

The following services are covered even if performed in connection with an abortion that is not covered:

- ◆ Services that would have been performed on a pregnant woman regardless of whether she was seeking an abortion, including:
  - Pregnancy tests.
  - Tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis).
  - Laboratory tests routinely performed on a pregnant patient, such as pap smear and urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B, and blood typing.
- ◆ Charges for all services, tests and procedures performed post abortion for complications of a non-covered therapeutic abortion, including charges for:
  - Services following a septic abortion.
  - A hospital stay beyond the normal length of stay for abortions.


NOTE: Family planning or sterilization must not be billed on the same claim with an abortion service. Bill these services separately from the abortion claim.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 13
		Date May 1, 2008

#### **(4) Noncovered Services**

The following abortion-related services are not allowed when the abortion is not covered by federal or state criteria:

- ◆ Physician and surgical charges for performing the abortion, including the usual, uncomplicated preoperative and postoperative care and visits related to performing the abortion.
- ◆ Hospital or clinic charges associated with the abortion, such as:
  - The facility fee for use of the operating room,
  - Supplies and drugs necessary to perform the abortion, and
  - Charges associated with routine, uncomplicated preoperative and postoperative visits by the patient.
- ◆ Physician and certified registered nurse anesthetist charges for administering the anesthesia necessary to induce or perform an abortion.
- ◆ Drug charges for medication usually provided to or prescribed for a patient who undergoes an uncomplicated abortion, including:
  - Routinely provided oral analgesics, and
  - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH negative women who have an abortion).
- ◆ Charges for other laboratory tests performed before performing the noncovered abortion to determine the anesthetic or surgical risk of the patient (e.g., CBC, electrolytes, blood typing).
- ◆ Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- ◆ Charges for uterine ultrasounds performed immediately following an abortion.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 14
		Date May 1, 2008

## b. Sterilizations

“Sterilization” means any medical procedure, treatment, or operation for the purpose of rendering a person incapable of reproducing which is not:

- ◆ A necessary part of the treatment of an existing illness, or
- ◆ Medically indicated as an accompaniment to an operation of the genitourinary tract.

For purpose of this definition, mental illness or retardation is not considered an illness or injury.

NOTE: Reversal of sterilization **is not** a covered Medicaid service.


### (1) Conditions for Payment

Medicaid payment may be made for the sterilization of a member when the following conditions are met:

- ◆ The member to be sterilized must voluntarily request the service.
- ◆ A knowledgeable informant must give the member to be sterilized an explanation of the procedures to be performed, upon which the person can base the consent for sterilization.
- ◆ An “informed consent” is required. The member must be age 21 or over when the consent form is signed. The member must be mentally competent and noninstitutionalized in accordance with the definitions below.
- ◆ The member to be sterilized must be advised that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing future care or loss of other program benefits to which the member might otherwise be entitled.

Medicaid payment shall **not** be made for sterilization of a member who is:

- ◆ Under 21 at the time of consent, or
- ◆ Legally mentally incompetent or institutionalized.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	15 <hr/> Date May 1, 2008

A “legally mentally incompetent person” is a person who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the court declares the person competent for purposes that include the ability to consent to sterilization.

An “institutionalized person” is a person who is:

- ◆ Involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- ◆ Confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

A claim for physician’s services for sterilization may be denied due either to failure to have the consent form signed at least 30 days but not more than 180 days before service is provided or failure to use the official *Consent for Sterilization*, 470-0835 or 470-0835S.

If so, any claim submitted by the hospital, anesthesiologists, assistant surgeon, or associated providers for the same procedure will also be denied. The hospital and other providers associated with the sterilization services must obtain a photocopy of the complete consent form, and attach it to their claim when submitted to IME for payment.


## (2) Requirements of Informed Consent

“Informed consent” means the voluntary knowing assent from the member to be sterilized after the member has been given a complete explanation of what is involved and has signed a written document to that effect.

The informed consent shall not be obtained while the member is:

- ◆ In labor or childbirth,
- ◆ Seeking to obtain or obtaining an abortion, or
- ◆ Under the influence of alcohol or other substance that affects the member’s state of awareness.

The member must be 21 years of age or older at the time of consent.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 16
		Date May 1, 2008

The “informed consent” must be obtained at least 30 days but not more than 180 days before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs.

When emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent form was obtained for the exception to be approved.

When a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed for the exception to be approved.

If the member is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. A witness of the member’s choice may accompany the member.

The elements of explanation that must be provided are:

- ◆ A thorough explanation of the procedures to be followed and the benefits to be expected.
- ◆ A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- ◆ Counseling concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure. (Reversal of sterilization **is not** a covered Medicaid service.)
- ◆ An offer to answer any inquiries concerning the proposed procedures.

### **(3) Consent for Sterilization, 470-0835 and 470-0835S**

The member’s informed consent shall be obtained on form 470-0835 or 470-0835S, *Consent for Sterilization*. The *Consent for Sterilization* must be completely executed in all aspects according to these directions and attached to the claim in order to receive payment. No substitute form is accepted.

**CONSENT FOR STERILIZATION**

**NOTICE:** Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.

**CONSENT TO STERILIZATION**

I have asked for and received information about sterilization from \_\_\_\_\_ . When I first asked for the \_\_\_\_\_  
*doctor or clinic*

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FIP or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children.

I was told about temporary methods of birth control that are available and could be provided to me that would allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a \_\_\_\_\_.

The discomforts, risks, and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_  
 \_\_\_\_\_ day \_\_\_\_\_ year \_\_\_\_\_ month

I \_\_\_\_\_  
 hereby consent of my own free will to be sterilized by \_\_\_\_\_  
 \_\_\_\_\_, by a method called \_\_\_\_\_  
 \_\_\_\_\_ doctor

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or
  - Employees of programs or projects funded by that Department ,
- but only for the purpose of determining if federal laws were observed.

I have received a copy of this form.

Signature	Month	Day	Year
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The following race and ethnicity information is requested, but is not required:  
**Race and ethnicity designation (please check):**

- ☐ White (not of Hispanic origin)      ☐ Asian or Pacific Islander  
☐ Black (not of Hispanic origin)      ☐ American Indian or Alaska Native  
☐ Hispanic

**INTERPRETER'S STATEMENT**

*If an interpreter is provided to assist the person to be sterilized:*

I have translated the information and advice presented orally to the person to be sterilized by the person obtaining this consent. I have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter	Date
-------------	------

**STATEMENT OF PERSON OBTAINING CONSENT**

Before \_\_\_\_\_ signed the  
*name of person*

consent form, I explained to him/her the nature of the sterilization operation, \_\_\_\_\_, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of person obtaining consent	Date
Facility	
Address	

**PHYSICIAN'S STATEMENT**

Shortly before I performed a sterilization operation upon \_\_\_\_\_  
 \_\_\_\_\_ on \_\_\_\_\_

*name of person to be sterilized*      *date of sterilization operation*

I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that it is intended to be a \_\_\_\_\_  
*specify type of operation*

final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

**(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the person's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)**

(1) At least 30 days have passed between the date of the person's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the person's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery; person's expected date of delivery \_\_\_\_\_

☐ Emergency abdominal surgery: (describe circumstances): \_\_\_\_\_

Physician	Date
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## FORMULARIO DE CONSENTIMIENTO REQUERIDO

**NOTA:** Si en cualquier momento decide no hacerse esterilizar ello no resultara en que se le retiren o retengan cualquiera de los beneficios proporcionados por programas o proyectos que reciben fondos del gobierno federal.

### CONSENTIMIENTO PARA LA ESTERILIZACIÓN

He pedido y recibido información sobre la esterilización de \_\_\_\_\_.  
(doctor o clínica)

se me dijo que la decisión de hacerme esterilizar es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no hacerme esterilizar. Si decido no hacerme esterilizar, esta decisión no afectará mis derechos a cuidados o tratamiento futuros. No perderé ninguno de los beneficios de programas que reciben fondos federales, como por ejemplo FIP o Medicaid que esté recibiendo en la actualidad o que pueda recibir en el futuro.

Entiendo que la esterilización se considera permanente e irrevocable. He decidido que no quiero quedar embarazada, tener hijos o procrear hijos.

Se me ha informado acerca de los métodos anticonceptivos que están disponibles y que se me podrán proporcionar, los que si me permitirán tener un hijo o procrear un hijo en el futuro. He rechazado estas alternativas y he elegido el ser esterilizado(a).

Entiendo que seré esterilizado(a) por medio de una operación conocida bajo el nombre de \_\_\_\_\_. Los inconvenientes, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no se hará hasta por lo menos 30 días después de haber firmado este consentimiento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no hacerme esterilizar no resultará en que se me retiren cualquiera de los beneficios o servicios médicos proporcionados por fondos federales.

Tengo por lo menos 21 años de edad y nací el \_\_\_\_\_  
mes \_\_\_\_\_ año \_\_\_\_\_ día \_\_\_\_\_  
Yo, \_\_\_\_\_,  
por la presente consiento por mi propia voluntad a que me esterilice  
\_\_\_\_\_, por el método conocido como  
(doctor)

Mi consentimiento se vence a los 180 días de la fecha de mi firma.

También consiento a que este formulario y otros antecedentes médicos sean puestos a la disposición de:

- Representantes del Departamento de Salud, Educación y Bienestar (Department of Health, Education and Welfare) o
- Empleados de programas o proyectos que operan con fondos de ese departamento, pero solamente para determinar si se han cumplido las leyes federales.

He recibido una copia de este formulario.

firma	mes	día	año
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Se le pide que proporcione la siguiente información, pero esto no es obligatorio:

**Raza y Designación Étnica (haga una marca):**

- ☐ Negro (no de origen hispano) ☐ Indio Norteamericano o Nativo de Alaska  
☐ Hispano ☐ Blanco (no de origen hispano)  
☐ Asiático o de Islas del Pacífico

### DECLARACION DEL INTERPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada: He traducido la información y consejos incluidos dados en forma oral por la persona que obtiene este consentimiento, a la persona a ser esterilizada. También le he leído el formulario de consentimiento en el idioma \_\_\_\_\_ y le he explicado su contenido. Según mi mejor entender esta persona ha comprendido esta explicación.

intérprete	fecha
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### DECLARACION DE LA PERSONA QUE OBTIENE ESTE CONSENTIMIENTO

Antes de que \_\_\_\_\_ firmara este  
nombre de la persona

formulario de consentimiento, le he explicado la naturaleza de la operación para la esterilización llamada \_\_\_\_\_, y el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los inconvenientes, riesgos y beneficios que la acompañan.

Advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarios. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ninguno de los servicios de salud o cualquier otro beneficio proporcionado con fondos federales.

De acuerdo a mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece tener capacidad mental suficiente. Esta persona ha solicitado en forma voluntaria, con pleno conocimiento de lo que implica, que la esterilicen y parece comprender la naturaleza y consecuencias del procedimiento.

firma de la persona que obtiene el consentimiento	fecha
establecimiento	
dirección	

### DECLARACION DEL MEDICO

Poco antes de efectuar la operación para la esterilización de \_\_\_\_\_

el \_\_\_\_\_  
nombre de la persona a ser esterilizada fecha de la operación  
le expliqué la naturaleza de la operación llamada \_\_\_\_\_  
tipo de operación

así como el hecho de que es un procedimiento final e irrevocable, así como los inconvenientes, riesgos y beneficios derivados del mismo.

He advertido a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarios. Le he explicado que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su consentimiento puede ser retirado en cualquier momento y que por ello no perderá ninguno de los cuidados médicos o beneficios proporcionados por fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y tiene la suficiente capacidad mental. Ha pedido voluntariamente y con pleno conocimiento el ser esterilizado(a) y parece comprender la naturaleza y consecuencias del procedimiento.

**(Instrucciones para el uso de párrafos finales alternos:** Utilice el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, en que la esterilización se efectúa menos de 30 días después de la fecha de la firma del formulario de consentimiento. En dichos casos, deberá usarse el segundo párrafo de los que siguen. Tache el párrafo que no utilice.)


(1) Por lo menos treinta días han transcurrido entre la fecha en que la persona firmó el formulario de consentimiento y la fecha en que se efectuó la operación de esterilización.

(2) Esta esterilización fue efectuada menos de 30 días pero mas de 72 horas después de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y de la información requerida):

- ☐ Parto prematuro  
Fecha en que debiera haber ocurrido el parto: \_\_\_\_\_  
☐ Cirugía abdominal de emergencia: (describa las circunstancias)

médico	fecha
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 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page 17
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Date May 1, 2008

To view a sample of the English consent form 470-0835 on line, click [here](#). To view a sample of the Spanish consent form 470-0835S on line, click [here](#). You may obtain a supply of the form from IME on request.

All names, signatures and dates on the *Consent for Sterilization*, 470-0835 or 470-0835S, must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:

- ◆ The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the patient to be sterilized.
- ◆ The information requested pertaining to race and ethnicity may be supplied voluntarily by the member, but is not required.


It is the responsibility of the person obtaining the consent form to verify that the member requesting the sterilization is at least 21 years of age on the date that the patient signs the form. If there is any question pertaining to the true age of the member, the birth date must be verified.

Any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control that are available to the patient may complete the "Statement of Person Obtaining Consent."

The "Physician's Statement" must be completed fully and signed by the **physician performing the sterilization** and dated when signed.

One of the paragraphs at the bottom of this statement must be crossed out. Be sure to cross out the paragraph that does not apply to the situation. If paragraph two is appropriate, indicate the expected date of delivery and circumstances involving emergency abdominal surgery.

The only signatures that should be on the completed consent form are those of the patient, the interpreter, if interpretation services were provided, the person obtaining the consent, and the physician performing the sterilization.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 18
		Date May 1, 2008

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization that will submit a claim, e.g., hospital, anesthetist, assistant surgeon, etc.

### c. Hysterectomies

Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization, and only when one or more of the following conditions are met:

- ◆ The member or representative has signed an acknowledgment that she has been informed orally and in writing that the hysterectomy will make the member permanently incapable of reproducing.

The vehicle for transmitting the acknowledgement that the member received the explanation **before** the surgery should **not** be the *Consent for Sterilization*, 470-0835 or 470-0835S.


The statement must be signed by the member or representative and must be submitted with the claim for Medicaid payment. The following language is satisfactory for such a statement:

“Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.  
 (Date) (Signature of patient or person acting on her behalf) ”

This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement can be submitted to IME with the related claims.

- ◆ The member was already sterile before the hysterectomy. The physician must certify in writing that the patient was already sterile at the time of the hysterectomy and has stated the cause of the sterility. The following language is satisfactory for such a statement:

“Before the surgery, this patient was sterile and the cause of that sterility was \_\_\_\_\_.  
 (Physician’s signature) (Date)”

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 19
		Date May 1, 2008

This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement is submitted to IME with the related claims.

Any statement or documentation stating the cause of sterility must be **signed and dated by a physician**. This includes history and physical, operative reports, or claim forms.

- ♦ The hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible, and the physician includes a description of the nature of the emergency. The claim will be reviewed on an individual basis and will be permitted only in extreme emergencies.

Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus is a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information.


Copies of the statement or documentation required to determine the medical necessity of the hysterectomy shall be made available for every other Medicaid provider involved that will submit a claim, such as the hospital, anesthetist, or assistant surgeon.

## 9. Transportation

To help ensure that members have access to medical care within the scope of the program, the Department reimburses members under certain conditions for transportation to receive necessary medical care.

Except for "Care for Kids" services, payment is limited to situations when it is necessary for the member to travel outside the community to receive needed medical care or, when the member lives in a rural area, to travel to the nearest community to receive care.

Payment in all situations is limited to the nearest source of adequate and appropriate care. The member is reimbursed only for the distance to the nearest doctor, dentist, etc., who can provide the necessary service.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 20
		Date May 1, 2008

This policy is not intended to limit the free choice the member has concerning the practitioner from whom the member wishes to receive service. However, because of limited funds in the Medicaid program, payment can be made for transportation only to the nearest source of necessary care.

If you refer a Medicaid member to a specialist or a hospital in another community, the same policy applies. The Department will reimburse the member only for the distance to the nearest available specialist or hospital, unless the attending physician indicates that, in view of the diagnosis and condition of the member, a more distant specialist or hospital is the only appropriate source of care.

When there is a nearer specialist of the same type or a nearer hospital, the Department may be contacting you to verify the necessity of referral to the more distant physician or hospital, in order to document the necessity of reimbursing the member for the greater distance.

Under the EPSDT "Care for Kids" program, local transportation is available for screening, diagnosis, or treatment. If a member is in need of this service, contact the designated Department of Public Health agency for assistance. See the [Appendix](#) for list of designated agencies.

## C. CONTENT OF SCREENING EXAMINATION

A screening examination must include at least the following:

- ◆ Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
  - A developmental assessment.
  - An assessment of nutritional status.
- ◆ A comprehensive unclothed physical examination. This includes:
  - Physical growth.
  - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- ◆ Appropriate immunizations according to age and health history as recommended by the Iowa Department of Public Health.
- ◆ Health education, including anticipatory guidance.
- ◆ Hearing and vision screening.



- ◆ Appropriate laboratory tests. These shall include:
  - Hematocrit or hemoglobin.
  - Rapid urine screening.
  - Lead toxicity screening for all children ages 12 to 72 months.
  - Tuberculin test, when appropriate.
  - Hemoglobinopathy, when appropriate.
  - Serology, when appropriate.
- ◆ Oral health assessment with direct dental referral for children over age 12 months.

## 1. History and Guidance

### a. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the patient's medical history. It includes an assessment of both physical and mental health development. Take the patient's medical history from the patient, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the patient's history.

Take or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- ◆ Identification of specific concerns.
- ◆ Family history of illnesses.
- ◆ The client's history of illnesses, diseases, allergies, and accidents.
- ◆ Information about the client's social or physical environment which may effect the client's overall health.
- ◆ Information on current medications or adverse reaction/responses due to medications.
- ◆ Immunization history.
- ◆ Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background.
- ◆ Identification of health resources currently used.



## b. Developmental Screening

Screening is a “brief assessment procedure designed to identify children who should receive more intensive diagnosis or assessment.” The primary purpose of **developmental screening** is to identify children who may need more comprehensive evaluation.

The use of validated screening tools improves detection of problems at the earliest possible age. Each developmental screening instrument is accompanied by an interpretation and report (e.g., a score or designation as normal or abnormal). Any interventions or referrals based on abnormal findings should be documented as well.

Developmental screening for young children should include the following four areas:

- ◆ Speech and language,
- ◆ Fine and gross motor skills,
- ◆ Cognitive skills, and
- ◆ Social and emotional behavior.

In screening children from birth to six years of age, it is recommended that you select recognized instruments. The best instruments have good psychometric properties, including adequate sensitivity, specificity, validity, and reliability, and have been standardized on diverse populations.

Parent report instruments such as the *Parents' Evaluation of Developmental Status* (PEDS), *Ages and Stages Questionnaires*, and the *Child Development Review* have excellent psychometric properties and require a minimum of time.

No list of specific instruments is required for identifying developmental problems of older children and adolescents. However, the following principles should be considered in developmental screening:

- ◆ Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional, or other familiar person.
- ◆ Incorporate and review this information in conjunction with other information gathered during the physical examination.



- ◆ Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of the child as a component of overall health and well-being, given the child's age and culture.
- ◆ Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.
- ◆ Screening should not result in a label or premature diagnosis being assigned to a child. Report only that a condition was referred or that diagnostic treatment services are needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.

When you or the parent has concerns or questions regarding the functioning of the child in relation to expected ranges of activities after screening, make referral or developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

**Developmental surveillance** is different than developmental testing. Developmental surveillance is a flexible, continuous process in which knowledgeable professionals perform skilled observations of children during the provision of health care.

Developmental surveillance is an important technique, which includes questions about the development as a part of the general developmental survey or history. It is not a "test" as such, and is not billable as a developmental screen.

Health care providers often use age-appropriate developmental checklists to record milestones during preventative care visits as part of developmental surveillance. A surveillance tool for children from birth through age five, the *Iowa Child Health and Developmental Record* (CHDR), is available at <http://www.iowaepsdt.org/>.

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under treatment. Focus screening on areas of special concern, such as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.



For further information on developmental screening, see:

- ◆ The Care for Kids Provider web site at: <http://www.iowaepsdt.org/>;
- ◆ The Developmental Behavioral Pediatrics Online site of the American Academy of Pediatrics at: <http://www.dbpeds.org/>;
- ◆ The Assuring Better Child Development and Health (ABCD) Electronic Resource Center of the National Academy for State Health Policy at: [www.abcdresources.org](http://www.abcdresources.org);
- ◆ The Commonwealth Fund's Child Development and Preventative Care web site at: [http://www.commonwealthfund.org/programs/programs\\_list.htm](http://www.commonwealthfund.org/programs/programs_list.htm); or
- ◆ The National Center of Home Initiatives for Children with Special Needs web site of the American Academy of Pediatrics at: <http://www.medicalhomeinfo.org/screening/index.html>

#### c. **Mental Health Assessment**

Mental health assessment should capture important and relevant information about the patient as a person. It may include a psychosocial history such as:

- ◆ The patient's **life-style**, home situation, and "significant others."
- ◆ A **typical day**: how the patient spends the time from getting up to going to bed.
- ◆ **Religious and health beliefs** of the family relevant to perceptions of wellness, illness, and treatment, and the patient's outlook on the future.
- ◆ **Sleep**: amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.
- ◆ **Toileting**: methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.
- ◆ **Speech**: hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.
- ◆ **Habits**: bed rocking, head banging, tics, thumb sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.





- ♦ **Discipline:** parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.
- ♦ **Schooling** experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.
- ♦ **Sexuality:** relations with members of opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education parents have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.
- ♦ **Personality:** degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self image.

Source: Boyle Jr., W.E. and Hoekelman, R.A. The Pediatric History, In Hoekelman, R.A. ed. Primary Pediatric Care, Second edition, 1992.

Clinical screening tools can increase the identification of psychosocial problems and mental disorders in primary care settings. Moreover, such tools can provide an important framework for discussing psychosocial issues with families. These screening tools can be grouped into three general categories:

- ♦ Broad psychosocial tools that assess overall functioning, family history, and environmental factors; deal with a wide range of psychosocial problems; and identify various issues for discussion with the child or adolescent and family.

An example of this type of tool is the *Pediatric Intake Form*, which can be used to assess such issues as parental depression and substance use, gun availability, and domestic violence (Kemper and Kelleher, 1996a, 1996b).

- ♦ Tools that provide a general screen for psychosocial problems or risk the children and adolescents, such as the *Pediatric Symptom Checklist* (Jellinek et al., 1998, 1999).
- ♦ Tools that screen for specific problems, symptoms, and disorders, such as the *Conner's Rating Scales for ADHD* (Conners, 1997) and the *Children's Depression Inventory* (Kovacs, 1992).



Often a broader measure such as the *Pediatric Symptom Checklist* is used first, followed by a more specific tool focused on the predominant symptoms for those that screen positive on the broader measure.

Some of the more specific tools may not be readily available to primary care health professionals or may require specialized training.

Source: Jellinek M, Patel BP, Froehle MC, eds. 2002. Bright Futures in Practice: Mental Health – Volume I. Practice Guide. Arlington, VA: National Center for Education in Maternal and Child Health.

To view the *Pediatric Symptom Checklist* in the Bright Futures Mental Health Tool Kit, see

[http://www.brightfutures.org/mentalhealth/pdf/professionals/ped\\_symp\\_ton\\_chklst.pdf](http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_symp_ton_chklst.pdf)

#### **d. Health Education/Anticipatory Guidance**

Health education that includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- ◆ Assist the parents and youth in understanding what to expect in terms of the child's development.
- ◆ Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *2000 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Second Edition, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 356-1964, (888) 434-4MCH, or <http://www.ncemch.org/>.

View this list as a guideline only. It does not require the inclusion of topics that are inappropriate for the child or limit topics that are appropriate for the child.



### **Suggested Health Education Topics: Birth - 18 Months**

#### ***Oral Health***

Appropriate use of bottle and breast feeding	Non-nutritive sucking (thumb, finger, and pacifier)
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Teething and tooth eruption
Infant oral care: cleaning teeth and gums	First dental visit by age one
Early childhood caries	Feeding and snacking habits: exposure to carbohydrates and sugars
Transmission of oral bacteria	Use of cup and sippy cup

#### ***Injury Prevention***

Infant/child CPR	Exposure to sun and heat
Child care options	Safety locks
Child safety seat restraint	Lock up chemicals
Child safety seats	Restricted play areas on the farm
Importance of protective helmets	Smoke detectors
Electric outlets	Stairway gates, walkers, cribs
Animals/pets	Syrup of ipecac, poison control
Hot water heater temperature	Emergency telephone numbers
Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder, plastic bags	Water precautions: buckets, tubs, small pools

#### ***Mental Health***

Adjustment to new baby	Sibling rivalry
Balancing home, work, and school	Support from spouse and friends
Caretakers expectations of infant development	Recognizing unique temperament
Responding to infant distress	Creating stimulating learning environments
Baby self regulation	Fostering baby caregiver attachment
Child care	

#### ***Nutrition***

Bottle propping	Managing meal time behavior
Breast or formula feeding to 1 year	Self feeding
Burping	Snacks
Fluid needs	Weaning
Introduction of solid foods 4-6 months	



***Other Preventive Measures***

Back sleeping	Effects of passive smoking
Bowel patterns	Fever
Care of respiratory infections	Hiccoughs
Crying or colic	Importance of well-child visits

**Suggested Health Education Topics: 2 - 5 Years**

***Oral Health***

Appropriate use of bottle and breast feeding	Teething and tooth eruption
Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: parental tooth brushing and flossing when the teeth touch	Feeding and snacking habits: exposure to carbohydrates and sugars
Gingivitis and tooth decay	Use of sippy cup
Non-nutritive sucking (thumb, finger and pacifier)	Dental injury prevention
	Sealants on six-year molars

***Injury Prevention***

CPR training	Purchase of bicycles
Booster car seat	Put up warning signs
Burns and fire	Restricted play areas
Farm hazards: manure pits, livestock, corn cribs, grain auger, and grain bins	Street danger
Dangers of accessible chemicals	Teach child how to get help
Importance of protective helmets	Toys
Machinery safety	Tricycles
No extra riders on tractor	Walking to school
Play equipment	Water safety
	Gun storage

***Mental Health***

Adjustment to increasing activity of child	Child care
Balancing home, work, and school	Sibling rivalry
Helping children feel competent	Managing emotions

***Nutrition***

Appropriate growth pattern	Managing meal time behavior
Appropriate intake for age	Physical activity
Control issues over food	Snacks



***Other Preventive Measures***

Adequate sleep	TV watching
Care of illness	Importance of preventative health visits
Clothing	Age-appropriate sexuality education
Common habits	School readiness
Social skills	Smoke-free environments
Safety rules regarding strangers	
Toilet training	

**Suggested Health Education Topics: 6 - 12 Years**

***Oral Health***

Fluoride exposure: toothpaste, water, topical fluoride and supplements	Regular dental visits
Oral care: supervised tooth brushing and flossing	Dental referral: orthodontist
Gingivitis and tooth decay	Diet and snacking habits: exposure to carbohydrates, sugars, and pop
Non-nutritive sucking (thumb, finger, and pacifier)	Dental injury prevention
Permanent tooth eruption	Sealants on 6- and 12-year molars
	Mouth guards for sports
	Smoking and smokeless tobacco

***Injury Prevention***

Bike (helmet) safety	Emergency telephone numbers
Car safety	Machinery safety
CPR training	Mowing safety
Dangers of ponds and creeks	Self-protection tips
Electric fences	Sports safety
Farm hazards: corn cribs, grain auger, gravity flow wagon, livestock	Street safety
Fire safety	Tractor safety training
Gun and hunter safety	Water safety
	High noise levels

***Mental Health***

Discipline	Developing self esteem
Emotional, physical, and sexual development	Nurturing friendships
Handling conflict	Peer pressure and adjustment
Positive family problem solving	School-related concerns
	Sibling rivalry



***Nutrition***

Appropriate intake for age	Inappropriate dietary behavior
Breakfast	Managing meal time behavior
Child involvement with food decisions	Peer influence
Food groups	Physical activity
	Snacks

***Other Preventive Measures***

Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
Smoke-free environments	Stress
	Television viewing

**Suggested Health Education Topics: Adolescent (13 - 21 Years)**

***Oral Health***

Fluoride exposure: toothpaste, water and topical fluoride	Diet and snacking habits: exposure to carbohydrates, sugars and pop
Oral care: tooth brushing and flossing	Dental injury prevention
Gingivitis, periodontal disease and tooth decay	Sealants on 6- and 12-year molars
Permanent tooth eruption	Mouth guards for sports
Regular dental visits	Smoking and smokeless tobacco
Dental referral: orthodontist and oral surgeon for third molars	Drug use (methamphetamines)
	Oral piercing

***Development***

Normal biopsychosocial changes of adolescence

***Gender Specific Health***

Abstinence education	Gender-specific sexual development
Contraception, condom use	Sexual orientation
HIV counseling or referral	Sexual responsibility, decision making
Self breast exam	Sexually transmitted diseases
Self testicular exam	Unintended pregnancy
Sexual abuse, date rape	

***Health Consumer Issues***

Selection and purchase of health devices or items	Selection and use of health services
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***Injury Prevention***

CPR and first aid training	ROPS (roll over protective structure)
Dangers of farm ponds and creeks	Helmet usage
Falls	Smoke detector
Firearm safety, hunting practices	Sports recreation, workshop
Gun and hunter safety	laboratory, job, or home injury
Hearing conservation	prevention
High noise levels	Over exposure to sun
Machinery safety	Tanning practices
Seat belt usage	Violent behavior
Motorized vehicle safety (ATV, moped, motorcycle, car, trucks)	Water safety
	Handling agricultural chemicals

***Nutrition***

Body image, weight issues	Food fads, snacks, fast foods
Caloric requirements by age and gender	Selection of fitness program by need, age, and gender
Balanced diet to meet growth needs	Special diets
Exercise, sports, and fitness	

***Personal Behavior and Relationships***

Communication skills	Community involvement
Dating relationships	Relationships with adults and peers
Decision making	Self esteem building
Seeking help if feeling angry, depressed, hopeless	Stress management and reduction
	Personal responsibility

***Substance Use***

Alcohol and drug cessation	Riding with intoxicated driver
Counseling or referral for chemical abuse	Sharing of drug paraphernalia
Driving under the influence	Steroid or steroid-like use
HIV counseling and referral	Tobacco cessation

***Other Preventative Measures***

Adequate sleep	Safety regarding strangers
Clothing	Age-appropriate sexuality education
Exercise	Social skills
Hygiene	Preparation of girls for menarche
Importance of preventative health visits	Sports
Smoke-free environments	Stress
	Television viewing



## 2. Physical Examination

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- ◆ General appearance.
- ◆ Assessment of all body systems.
- ◆ Height and weight.
- ◆ Head circumference through 2 years of age.
- ◆ Blood pressure starting at 3 years of age.
- ◆ Palpation of femoral and brachial (or radial) pulses.
- ◆ Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education.
- ◆ Pelvic examination, recommended for women 18 years old and older, if sexually active, or significant menstrual problems.
- ◆ Testicular examination, include age-appropriate self-examination instructions and health education.

### a. Growth Measurements

- ◆ **Recumbent Length:** Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8th inch.
- ◆ **Height:** Measure children over 2 years of age using a standing height board or stadiometer.

If the child is two years old or older and is less than 31 1/2 inches tall, the height measurement does not fit on the 2-20 year old chart. Therefore, you must measure the child's recumbent length and plot the length on the Birth-36 month growth chart. Read and record the measurement to the nearest 1/8th inch.

Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.





- ♦ **Weight:** Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.

- ♦ **Body Mass Index:** Body Mass Index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals.

Examples: 37 pounds 4 ounces = 37.25 pounds

41 ½ inches = 41.5 inches

2. Insert the values into the formula:

[weight (lb) / height (in) / height (in)] X 703 = BMI

Example: (37.25 lb / 41.5 in / 41.5 in) X 703 = 15.2

A reference table can also be used to calculate BMI. This table can be downloaded from the Centers for Disease Control and Prevention web site at [www.cdc.gov/growthcharts](http://www.cdc.gov/growthcharts).

For children, BMI values are plotted against age. If the BMI-for-age is less than or equal to the 5th percentile, the child is considered underweight. If the BMI-for-age is between the 85th and 94th percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95th percentile are considered overweight.

- ♦ **Plotting Measurements:** Record measurements as soon as they are taken to reduce errors.

Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for the children under 2 years of age. For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.



Example of calculating child's age:

	Year		Month		Day		
Date of visit	<del>93</del>	92	<del>7</del>	<del>6</del>	18	<del>15</del>	45 July 15, 1993
Birth date	-91		-10			-28	October 28, 1991
Age	1		8			17	= 20 months, 17 days or 21 months

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.


Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.

Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract birth date from the clinic visit date. You may borrow 30 days from the months column or 12 months for the year column when subtracting.

Common errors result from unbalanced scales, failure to remove shoes and heavy clothing, use of an inappropriate chart for recording the results, and uncooperative children.

◆ **Referral and Follow-up of Growth in Infants and Children**

- Nutrition. See criteria in [Nutritional Status](#).
- Medical. Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:
  - Growth of less than 2 inches/year for ages 3 to 10 years.
  - A 25 percentile greater change in weight/height percentile rank.
  - Sudden weight gain or loss.
  - More than 2 SD below or above the mean for height.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 35
		Date May 1, 2008

**b. Head Circumference**

Measure the head circumference at each visit until the child is two years old. Measure with a nonstretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease & Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- ◆ Above the 95th percentile.
- ◆ Below 5th percentile.
- ◆ Reflecting a major change in percentile levels from one measurement to the next or over time.

**c. Blood Pressure**

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, do a blood pressure only if other physical findings suggest it may be needed.

In 1996, the National Health, Lung and Blood Institute published new blood pressure standards for children and adolescents. The standards are based on height as well as age and gender for children and adolescents from one through 17 years old.

This is a change from the past, when height and weight were both thought to be correlates of blood pressure. The investigators determined height was a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in Tables 1 and 2.



**Table 1. Blood Pressure Levels for Boys Aged 1 to 17 Years by Percentile of Height**

Boys		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	94	95	97	98	100	102	102	50	51	52	53	54	54	55
	95th	98	99	101	102	104	106	106	55	55	56	57	58	59	59
2 yr	90th	98	99	100	102	104	105	106	55	55	56	57	58	59	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
3 yr	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	111	112	113	63	63	64	65	66	67	67
4 yr	90th	102	103	105	107	109	110	111	62	62	63	64	65	66	66
	95th	106	107	109	111	113	114	115	66	67	67	68	69	70	71
5 yr	90th	104	105	106	108	110	112	112	65	65	66	67	68	69	69
	95th	108	109	110	112	114	115	116	69	70	70	71	72	73	74
6 yr	90th	105	106	108	110	111	113	114	67	68	69	70	70	71	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
7 yr	90th	106	107	109	111	113	114	115	69	70	71	72	72	73	74
	95th	110	111	113	115	116	118	119	74	74	75	76	77	78	78
8 yr	90th	107	108	110	112	114	115	116	71	71	72	73	74	75	75
	95th	111	112	114	116	118	119	120	75	76	76	77	78	79	80
9 yr	90th	109	110	112	113	115	117	117	72	73	73	74	75	76	77
	95th	113	114	116	117	119	121	121	76	77	78	79	80	80	81
10 yr	90th	110	112	113	115	117	118	119	73	74	74	75	76	77	78
	95th	114	115	117	119	121	122	123	77	78	79	80	80	81	82
11 yr	90th	112	113	115	117	119	120	121	74	74	75	76	77	78	78
	95th	116	117	119	121	123	124	125	78	79	79	80	81	82	83
12 yr	90th	115	116	117	119	121	123	123	75	75	76	77	78	78	79
	95th	119	120	121	123	125	126	127	79	79	80	81	82	83	83
13 yr	90th	117	118	120	122	124	125	126	75	76	76	77	78	79	80
	95th	121	122	124	126	128	129	130	79	80	81	82	83	83	84
14 yr	90th	120	121	123	125	126	128	128	76	76	77	78	79	80	80
	95th	124	125	127	128	130	132	132	80	81	81	82	83	84	85
15 yr	90th	123	124	125	127	129	131	131	77	77	78	79	80	81	81
	95th	127	128	129	131	133	134	135	81	82	83	83	84	85	86
16 yr	90th	125	126	128	130	132	133	134	79	79	80	81	82	82	83
	95th	129	130	132	134	136	137	138	83	83	84	85	86	87	87
17 yr	90th	128	129	131	133	134	136	136	81	81	82	83	84	85	85
	95th	132	133	135	136	138	140	140	85	85	86	87	88	89	89


\* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.



**Table II. Blood Pressure Levels for Girls Aged 1 to 17 Years by Percentile of Height**

GIRLS		Systolic BP (mm Hg) by percentile of height*							Diastolic BP (mm Hg) by percentile of height*						
Age	Percentile	5%	10%	25%	50%	75%	90%	95%	5%	10%	25%	50%	75%	90%	95%
1 yr	90th	97	98	99	100	102	103	104	53	53	53	54	55	56	56
	95th	101	102	103	104	105	107	107	57	57	57	58	59	60	60
2 yr	90th	99	99	100	102	103	104	105	57	57	58	58	59	60	61
	95th	102	103	104	105	107	108	109	61	61	62	62	63	64	65
3 yr	90th	100	100	102	103	104	105	106	61	61	61	62	63	63	64
	95th	104	104	105	107	108	109	110	65	65	65	66	67	67	68
4 yr	90th	101	102	103	104	106	107	108	63	63	64	65	65	66	67
	95th	105	106	107	108	109	111	111	67	67	68	69	69	70	71
5 yr	90th	103	103	104	106	107	108	109	65	66	66	67	68	68	69
	95th	107	107	108	110	111	112	113	69	70	70	71	72	72	73
6 yr	90th	104	105	106	107	109	110	111	67	67	68	69	69	70	71
	95th	108	109	110	111	112	114	114	71	71	72	73	73	74	75
7 yr	90th	106	107	108	109	110	112	112	69	69	69	70	71	72	72
	95th	110	110	112	113	114	115	116	73	73	73	74	75	76	76
8 yr	90th	108	109	110	111	112	113	114	70	70	71	71	72	73	74
	95th	112	112	113	115	116	117	118	74	74	75	75	76	77	78
9 yr	90th	110	110	112	113	114	115	116	71	72	72	73	74	74	75
	95th	114	114	115	117	118	119	120	75	76	76	77	78	78	79
10 yr	90th	112	112	114	115	116	117	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
11 yr	90th	114	114	116	117	118	119	120	74	74	75	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	79	79	80	81	81
12 yr	90th	116	116	118	119	120	121	122	75	75	76	76	77	78	78
	95th	120	120	121	123	124	125	126	79	79	80	80	81	82	82
13 yr	90th	118	118	119	121	122	123	124	76	76	77	78	78	79	80
	95th	121	122	123	125	126	127	128	80	80	81	82	82	83	84
14 yr	90th	119	120	121	122	124	125	126	77	77	78	79	79	80	81
	95th	123	124	125	126	128	129	130	81	81	82	83	83	84	85
15 yr	90th	121	121	122	124	125	126	127	78	78	79	79	80	81	82
	95th	124	125	126	128	129	130	131	82	82	83	83	84	85	86
16 yr	90th	122	122	123	125	126	127	128	79	79	79	80	81	82	82
	95th	125	126	127	128	130	131	132	83	83	83	84	85	86	86
17 yr	90th	122	123	124	125	126	128	128	79	79	79	80	81	82	82
	95th	126	126	127	129	130	131	132	83	83	83	84	85	86	86

\* Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	38 <hr/> Date May 1, 2008

### **(1) Use of Blood Pressure Tables in a Clinical Setting**

To use the tables, you need to measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age, and sex.

The National Heart, Lung and Blood Institute recommends to using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

### **(2) Interpretation of Blood Pressure Readings**

The interpretation of children and adolescents blood pressure measurements for height, age, and gender are as follows:

- ◆ Readings below the 90th percentile are considered normotensive.
- ◆ Reading between the 90th and 95th percentile are high normal and warrant further observation and identification of risk factors.
- ◆ Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.

#### **d. Oral Health Screening**

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive dental education is provided to the parents or guardians.

Unlike other health needs, dental problems are so prevalent that most children over 12 months will need diagnosis, evaluation, and treatment. An oral health screening that includes the following components must be documented in the child's record:

- ◆ Medical and dental history:
  - Current or recent medical conditions
  - Current medications used
  - Allergies



- Name of child's dentist
- Date of last dental visit or frequency of dental visits
- Use of fluoride by child (source of water, use of fluoridated toothpaste or other fluoride products)
- Current or recent dental problems or injuries
- Home care (frequency of brushing, flossing, or other oral hygiene practices)
- Snacking and feeding habits
- ◆ Oral evaluation
  - Number of teeth (for children up to age 12)
  - Presence of decay
  - Presence of demineralized areas (white spots)
  - Presence of visible plaque
  - Presence of gingivitis or other soft tissue conditions
  - Presence of enamel defects
  - Presence of sealants
  - Presence of restored teeth
- ◆ Provide age-appropriate oral health education to the child's parent or guardian. Education should be based on the findings of the oral health screening.
- ◆ Refer children to a dentist for:
  - Complete dental examination annually starting at 12 months and semiannually starting at 24 months, unless a dentist recommends more frequent visits;
  - Obvious or suspected dental caries;
  - Pain or injury to the oral tissue; and
  - Difficulty chewing

### **3. Laboratory Tests**

#### **a. Hemoglobin and Hematocrit**

One hematocrit or hemoglobin determination is suggested by the American Academy of Pediatrics during the first year, and in each of the following intervals:



- ◆ 9-12 months, if any of the following risk factors are present:
  - Qualify for EPSDT Care for Kids
  - Low socioeconomic status
  - Birth weight under 1500 grams
  - Whole milk given before 6 months of age (not recommended)
  - Low-iron formula given (not recommended)
- ◆ 11-20 years. Annual screening for females, if any of the following factors are present:
  - Qualify for EPSDT Care for Kids
  - Moderate to heavy menses
  - Chronic weight loss
  - Nutrition deficit
  - Athletic activity

A test for anemia may be performed at any age if there is:

- ◆ Medical indication noted in the physical examination
- ◆ Nutritional history of inadequate iron in the diet
- ◆ History of blood loss
- ◆ Family history of anemia

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185% of poverty and hemoglobin or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

#### **Fifth Percentile Criteria for Children**

Age/Years	Hematocrit	Hemoglobin
6 months up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.5
8 up to 12 years	35.4	11.9

#### **Female (non pregnant)**

12 up to 15 years	35.5	11.8
15 up to 18 years	35.9	12.0
18 up to 21 years	35.7	12.0





### Fifth Percent Criteria for Children

Age/Years	Hematocrit	Hemoglobin
<b>Male</b>		
12 up to 15 years	37.3	12.5
15 up to 18 years	39.7	13.3
18 up to 21 years	39.9	13.5

Source: "Recommendations to Prevent and Control Iron Deficiency in the United States," *Morbidity and Mortality Weekly Report*, April 3, 1998; Vol. 47, No. RR-3, pages 1-29.

#### b. Urinalysis

Depending on the success in obtaining a voided urine specimen, urinalysis is suggested:

- ◆ At 5 years
- ◆ Once from 11 through 20 years, preferable at 14 years

Use a dipstick that shows at least pH, glucose, protein, blood, and nitrates. Referral criteria should include:

- ◆ PH below 5 or above 9
- ◆ Glycosuria
- ◆ 2+ protein
- ◆ Positive nitrates
- ◆ Trace or greater blood

#### c. Newborn Screening

Confirm during the infant's first visit that newborn screening was done. In Iowa newborn screening is mandatory for the following conditions:

- ◆ Congenital adrenal hyperplasia
- ◆ Galactosemia
- ◆ Hemoglobinopathies
- ◆ Hypothyroidism
- ◆ Phenylketonuria (PKU)
- ◆ Medium chain acyl Co-A dehydrogenase (MCAD) deficiency
- ◆ Biotinidase deficiency
- ◆ Hearing
- ◆ Cystic fibrosis
- ◆ Any other amino acid, organic acid, and fatty oxidation disorders detectable by tandem mass spectrometry



A current list of the screening panel can be found at:

<http://www.idph.state.ia.us/genetics>

**d. Hemoglobinopathy Screening**

Screen infants not born in Iowa and children of Caribbean, Latin American, Asian, Mediterranean, and African descent who were born before February 1988 for hemoglobin disorders. Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call 319-356-1400 for information.

**e. Tuberculin Testing**

The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin testing in **high-risk** children.

High-risk children include those in households where tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, or the Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and children in the homes of IV drug users, alcoholics, HIV positives, and prostitutes).

**f. Lead Testing**

Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

For more information or assistance on lead testing, screening, or case management, contact the Bureau of Lead Poisoning Prevention, Iowa Department of Public Health, 515-281-3479 or 1-800-972-2026.



### (1) Determining Risk Through Asking Questions

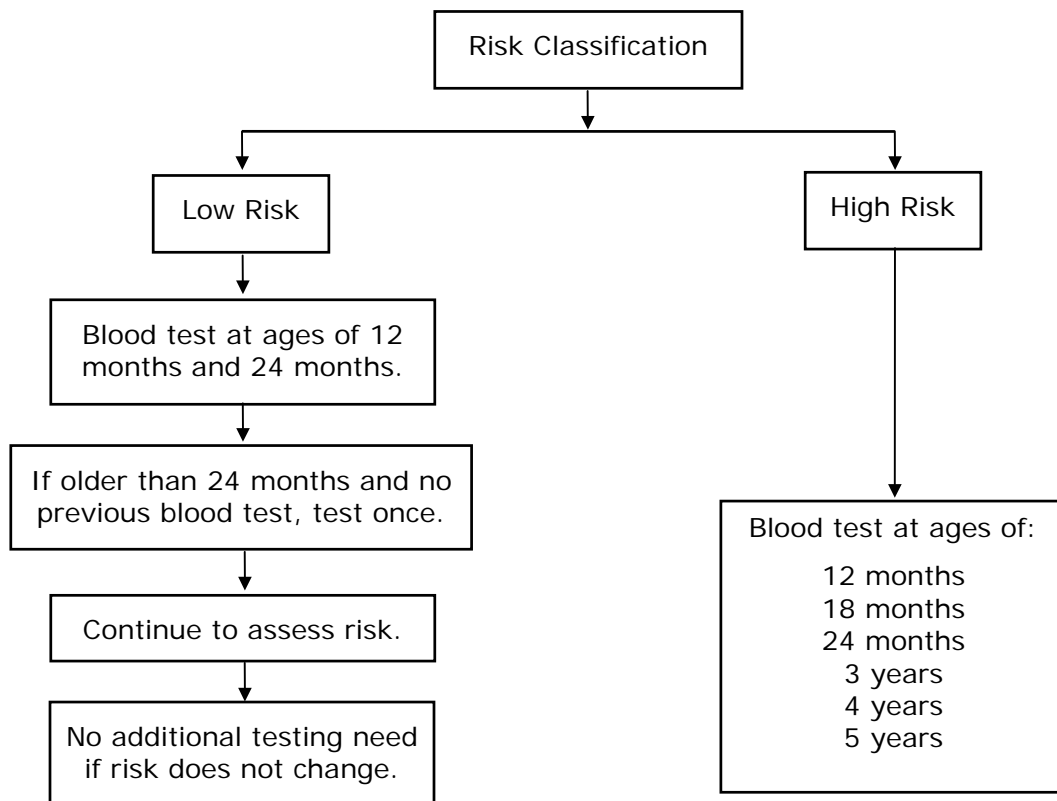
Beginning with the age of 12 months, ask the following questions for all children at each office visit to determine each child's risk for lead poisoning:

- ◆ Has your child ever lived in or regularly visited a house built before 1960 (including home, child care center, baby-sitter, relatives' home)?
- ◆ Have you noticed any peeling or chipping paint in or around the pre-1960 house that your child lives in or regularly visits?
- ◆ Is the pre-1960 home that your child lives in or regularly visits being remodeled or renovated by:
  - Stripping, sanding, or scraping indoor or outdoor paint?
  - Removing walls or tearing out lath and plaster?
- ◆ Does your child eat non-food items, such as dirt?
- ◆ Have any of your other children or their playmates had elevated lead levels  $\geq 15 \mu\text{g/dL}$ ?
- ◆ Does your child live with or frequently encounter an adult who works with lead on the job or in a hobby? (Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramic worker, stained glass worker, sheet metal worker, plumber.)
- ◆ Does your child live near a battery plant, battery recycling plant, or lead smelter?
- ◆ Do you give your child any home or folk remedies? (Examples: Azarcon, Greta, Pay-loo-ah)
- ◆ Does your child eat candy that comes from Mexico or is purchased from a Mexican grocery store?
- ◆ Has your child ever lived in Mexico, Central America, or South America or visited one of these areas for a period longer than two months?

If the answer to **any** of these questions is yes, the child is considered to be at high risk for lead poisoning and needs to be screened according to the high-risk screening schedule.



## (2) Basic Lead Testing Chart (Based on Risk and Age)



NOTE: If you see children at different ages than these, you can change these schedules to correspond with the ages when you do see children. However, the first test should not be done before 12 months unless the child is at extremely high risk for lead poisoning.

If capillary samples are used, see next page for follow-up of any level  $\geq 10$   $\mu\text{g/dL}$ .

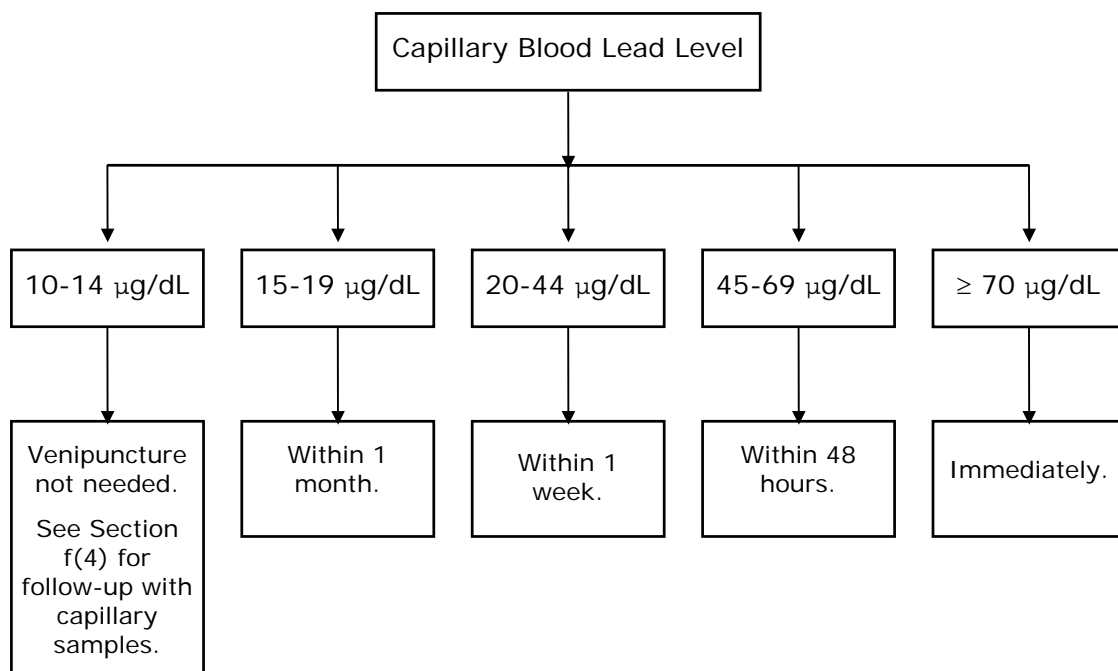
If venous samples are used, see [Follow-up of Elevated Blood Lead Levels \(10-14  \$\mu\text{g/dL}\$ \)](#), [Follow-up of Elevated Venous Blood Leads \(15-19  \$\mu\text{g/dL}\$ \)](#), and [Follow-up of Elevated Venous Levels \( \$\geq 20\$   \$\mu\text{g/dL}\$ \)](#) for follow-up of any level  $\geq 10$   $\mu\text{g/dL}$ .

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



### (3) Schedule for Obtaining Confirmatory Venipunctures

Children who have blood lead levels  $\geq 15$   $\mu\text{g/dL}$  on a capillary sample should have these levels confirmed on venous samples according to the timetables below.



If venous level  $< 9$   $\mu\text{g/dL}$ , return to regular blood lead testing schedule.

If venous level 10-14  $\mu\text{g/dL}$ , see [Follow-up of Elevated Blood Lead Levels \(10-14  \$\mu\text{g/dL}\$ \)](#).

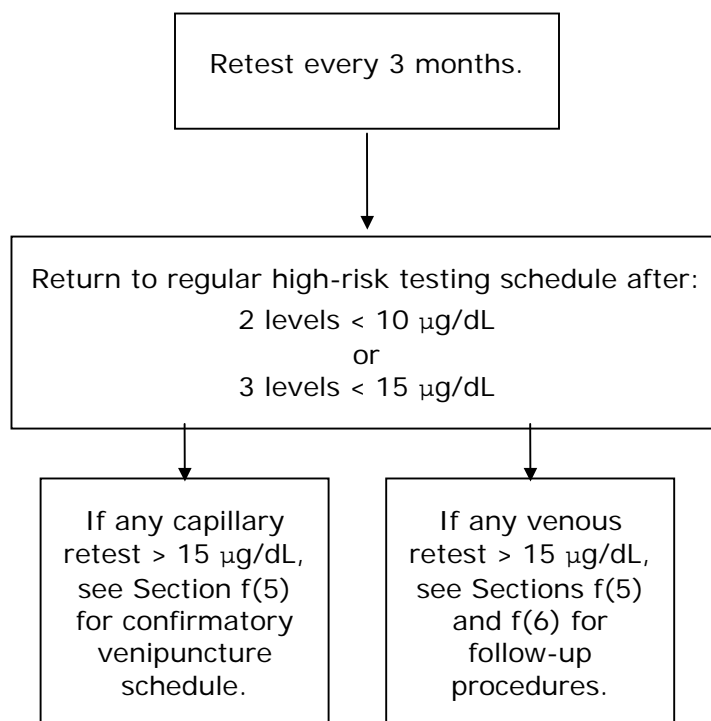
If venous level 15-19  $\mu\text{g/dL}$ , see [Follow-up of Elevated Venous Blood Leads \(15-19  \$\mu\text{g/dL}\$ \)](#).

If venous level  $\geq 20$   $\mu\text{g/dL}$ , see [Follow-up of Elevated Venous Levels \( \$\geq 20\$   \$\mu\text{g/dL}\$ \)](#).

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



#### (4) Follow-up of Elevated Blood Lead Levels (10-14 $\mu\text{g/dL}$ )

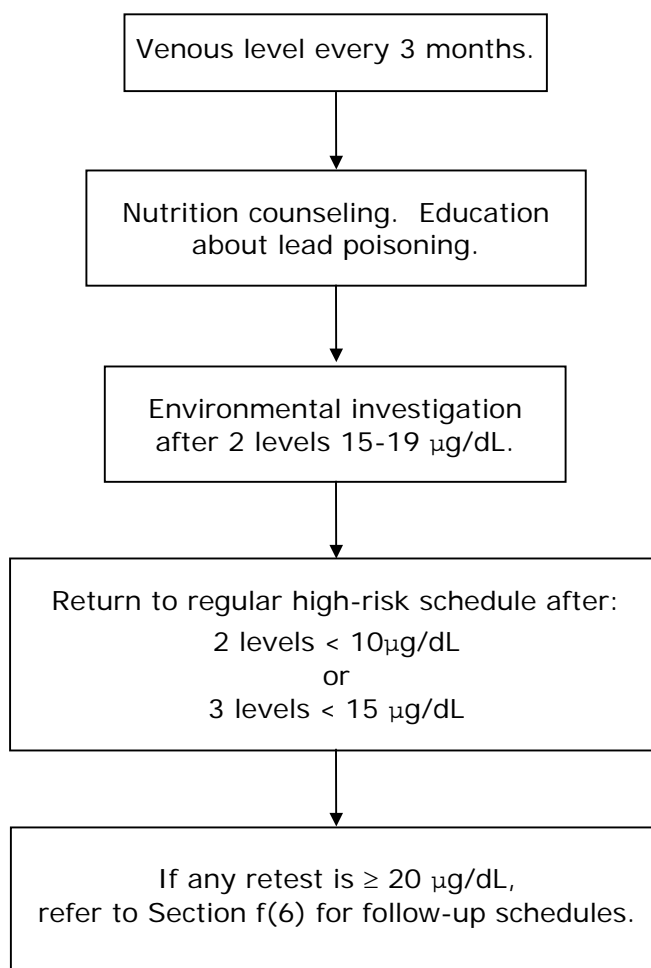


Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



### (5) Follow-up of Elevated Venous Blood Leads (15-19 $\mu\text{g}/\text{dL}$ )

All children who have had venous levels  $\geq 15 \mu\text{g}/\text{dL}$  are considered “high” risk regardless of initial risk assessment.

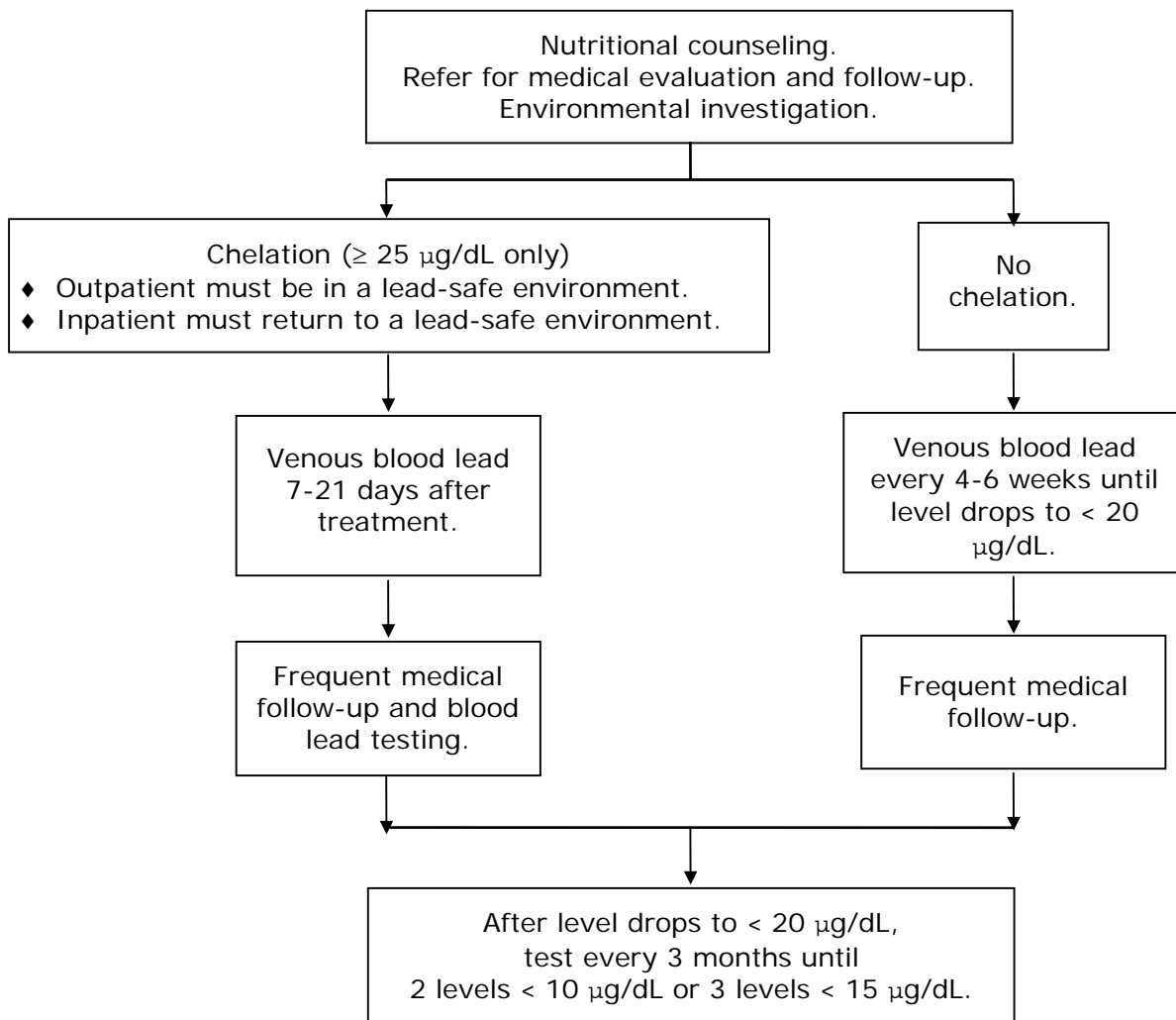


See [Timelines for Medical and Nutritional Follow-up](#) and [Timelines for Environmental Follow-up](#) for time frames for referrals.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



**(6) Follow-up of Elevated Venous Levels ( $\geq 20 \mu\text{g/dL}$ )**



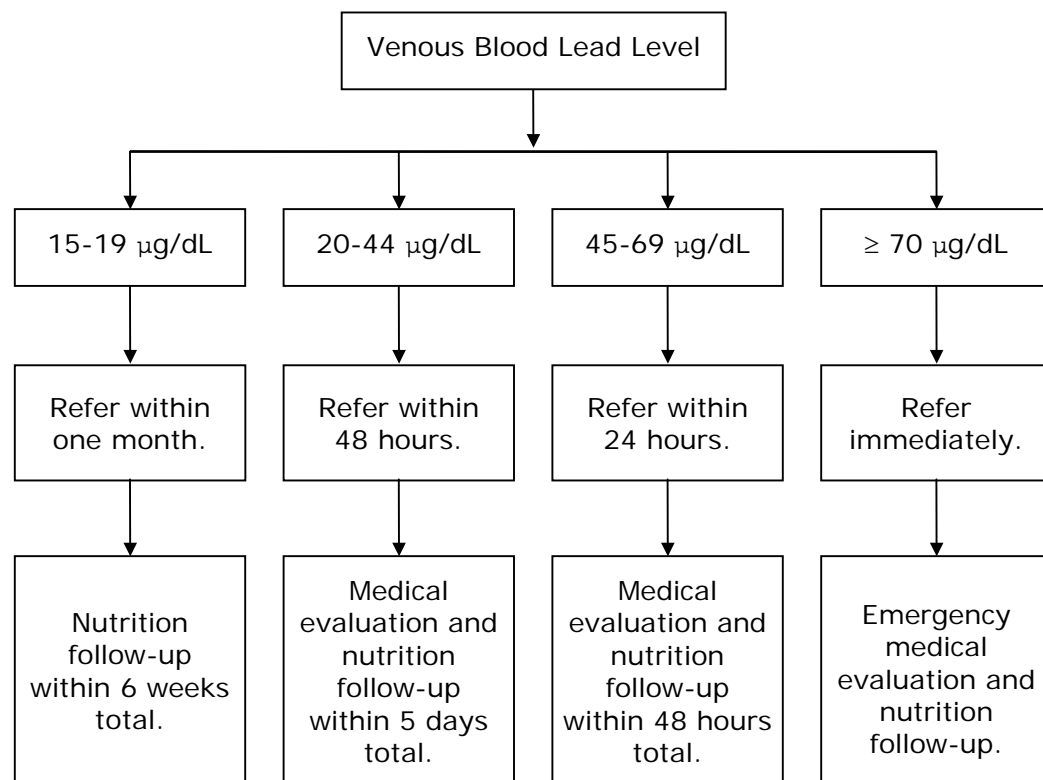
See [Timelines for Medical and Nutritional Follow-up](#) and [Timelines for Environmental Follow-up](#) for time frames for referrals.

Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).





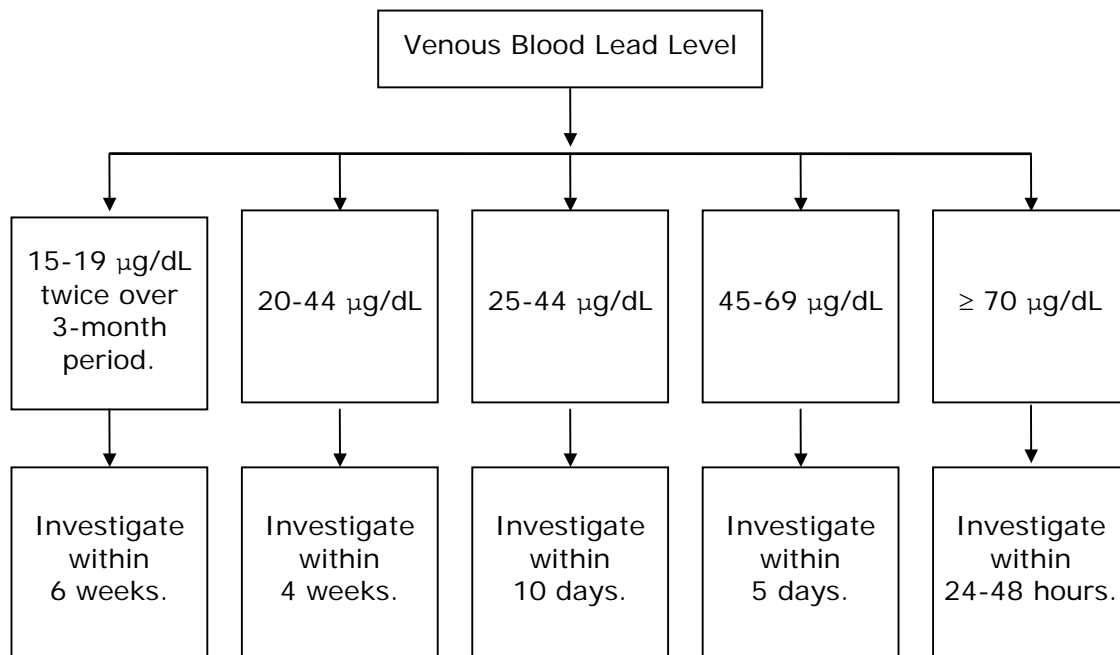
### (7) Timelines for Medical and Nutritional Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).



## (8) Timelines for Environmental Follow-up



Source: Iowa Department of Public Health (IDPH), *Statewide Plan for Childhood Blood Lead Testing* (January 2004).

### g. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (pap) smears are recommended for all sexually active females or at age 18 years if the sexual history is thought to be unreliable. High-risk individuals for cancer in situ are those who:

- ◆ Begin sexual activity in early teen years, and
- ◆ Have multiple partners.

Sexually active females should receive family planning counseling, including pap smears, self breast exams, and educate on prevention of sexually transmitted disease (STD).

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If first smear is unsatisfactory, repeat as soon as possible.



#### **h. Gonorrhea Test**

Testing for gonorrhea may be done on persons with:

- ◆ Multiple sexual partners or a sexual partner with multiple contacts.
- ◆ Sexual contacts with a person with culture-proven gonorrhea.
- ◆ A history of repeated episodes of gonorrhea.
- ◆ Educate on the prevention of sexually transmitted disease.
- ◆ Discuss how to use contraceptives and make them available.

#### **i. Chlamydia Test**

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., multiple sexual partners with multiple sexual contacts). For recent sexual partners of persons with positive tests for STD:

- ◆ Educate on the prevention of sexually transmitted diseases.
- ◆ Educate on the importance of contraception to prevent pregnancy.

### **4. Other Services**

Other services that must be included in the screening examination are:

- ◆ [Immunizations](#)
- ◆ [Assessment of nutritional status](#)
- ◆ [Vision screening](#)
- ◆ [Hearing screening](#)

#### **a. Immunization**

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90% of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in February 2002 reflect changes and challenges in vaccine delivery.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>.) You can obtain information about immunizations by contacting 1-800-232-4636 or 1-800-831-6293.



Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm> for a guide to contraindications to immunization.

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

Under the leadership of National Vaccine Advisory Committee (NVAC), standards were recently revised (<http://www.cdc.gov/vaccines/recs/vac-admin/>). The revised standards focus on:

- ◆ Making vaccines easily accessible
- ◆ Effectively communicating vaccination information
- ◆ Implementing strategies to improve vaccination rates
- ◆ Developing community partnerships to reach target patient populations

Provide the recommended childhood immunization schedule for the United States for January-December of the current year. These recommendations are approved by:

- ◆ The Advisory Committee on Immunization Practices (ACIP).
- ◆ The American Academy of Pediatrics.
- ◆ The American Academy of Family Physicians.

The recommended childhood and adolescent immunization schedule can be accessed on the following web sites: <http://www.cdc.gov/vaccines>, [www.aap.org](http://www.aap.org), or [www.aafp.org](http://www.aafp.org).

#### **b. Nutritional Status**

To assess nutritional status, include:

- ◆ Accurate measurements of height and weight.
- ◆ A laboratory test to screen for iron deficiency anemia (see [Hemoglobin and Hematocrit](#) for suggested screening ages).



- ◆ Questions about dietary practices to identify:
  - Diets deficient or excessive in one or more nutrients.
  - Food allergy, intolerance, or aversion.
  - Inappropriate dietary alterations.
  - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).
- ◆ Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.
- ◆ If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to the following criteria:
  - Parents or grandparent who at 55 years of age or less underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
  - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

#### **(1) Medical Evaluation Indicated (0-12 months)**

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- ◆ Measurements
  - Weight/height < 5th percentile or > 95th percentile (NCHS charts).
  - Weight/age < 5th percentile.
  - Major change in weight/height percentile rank (a shift in ranking of 25 percentile or greater.)
  - Flat growth curve (two months without an increase in weight/age of an infant below the 90th percentile weight/age).



- ◆ Laboratory tests
  - < Hct 32.9%
  - < Hgb 11 gm/dL (6-12 months)
  - $\geq 15$   $\mu\text{g/dL}$  blood lead level
- ◆ Health problems
  - Metabolic disorder.
  - Chronic disease requiring a special diet.
  - Physical handicap or developmental delay that may alter nutritional status.
- ◆ Physical examination: Abnormality of hair, skin, nails, eyes, teeth, or gums which indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

## (2) Medical Evaluation Indicated (1-10 years)

Use these criteria for referring a child for further medical evaluation of nutrition status:

- ◆ Measurements
  - Weight/length < 5th percentile or > 95th percentile for 12-23 months.
  - BMI for age < 5th percentile or > 95th percentile for 24 months and older.
  - Weight/height < 5th percentile or > 95th percentile (NCHS charts).
  - Weight/age < 5th percentile.
  - Major change in weight/height percentile rank (a shift in ranking of 25 percentile or greater).
  - Flat growth curve:

Age	Indicator
12 to 36 months	Two months without an increase in weight per age of a child below the 90th percentile weight per age.
3 to 10 years	Six months without an increase in weight per age of a child below the 90th percentile weight per age.



♦ Laboratory tests

Age	HCT %	HGB gm/dL
1 up to 2 years	32.9	11.0
2 up to 5 years	33.0	11.1
5 up to 8 years	34.5	11.4
8 up to 10 years	35.4	11.9

♦ Health problems

- Chronic disease requiring a special diet.
- Metabolic disorder.
- Family history of hyperlipidemias.
- Physical handicap or developmental delay that may alter nutritional status.

- ♦ Physical examination: Abnormality of hair, skin, nails, eyes, teeth, or gums that indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

### (3) Medical Evaluation Indicated (11-21 years)


Use these criteria for referring adolescents for further medical evaluation of nutritional status:

♦ Laboratory tests

Age	FEMALE		MALE	
	HCT %	HGB gm/dL	HCT %	HGB gm/dL
11 up to 12	35.4	11.9	35.4	11.9
12 up to 15	35.7	11.8	37.3	12.5
15 up to 18	35.9	12.0	39.7	13.3
18 up to 21	35.7	12.0	39.9	13.6

♦ Health problems

- Chronic disease requiring a special diet.
- Physical handicap or developmental delay that may alter nutritional status.
- Metabolic disorder.
- Family history of hyperlipidemias.
- Substance use or abuse.

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	56 <hr/> Date May 1, 2008

- Behaviors intended to change body weight, e.g. self-induced vomiting, bingeing and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise.
- Physical examination. Abnormality of hair, skin, nails, eyes, teeth, or gums that indicates poor nutrition; disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

Source: *Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents*. U.S. Department of Health and Human Services, September 1991.

### c. Vision

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examination of children is recommended as a part of the regular plan for continuing care beginning at three years of age.


At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

#### (1) Birth Through Two Years of Age

Eye evaluations of infants and children birth through two years of age should include:

- ◆ Eyelids and orbits
- ◆ External examinations
- ◆ Eye muscle balance
- ◆ Pupils
- ◆ Red reflex
- ◆ Motility
- ◆ Monocular fixational ability assessment



 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	57 <hr/> Date May 1, 2008

## (2) Two to Four Years of Age

In addition to the evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ years, children should receive objective vision testing using picture cards. (See the following [chart](#) for suggested tests.)

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the child is untestable on the second attempt.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the ophthalmoscope is used to evaluate the optic nerve and posterior eye structures.

## (3) At Five Years and Older

Children five years and older should receive all the examinations and screening previously described for younger children.


During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception. As the child reaches school age, refractive errors that may require eyeglasses for correction become important.

The most common refractive error is hyperopia or far-sightedness. Hyperopia, farsightedness, can cause problems in performing close work. Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning related vision problems.



VISION SCREENING GUIDELINES		
Function: Recommended Tests	Referral Criteria	Comments
<b>Distance visual acuity:</b> <ul style="list-style-type: none"><li>◆ Snellen letters</li><li>◆ Snellen numbers</li><li>◆ Tumbling E</li><li>◆ HOTV</li><li>◆ Picture tests<ul style="list-style-type: none"><li>• Allen figures</li><li>• LH test</li></ul></li></ul>	<b>Ages 3-5 years:</b> <ol style="list-style-type: none"><li>1. &lt;4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., &lt;10/20 or 20/40) or</li><li>2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40)</li></ol> <b>Ages 6 years and older:</b> <ol style="list-style-type: none"><li>1. &lt;4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., &lt;10/15 or 20/30)</li><li>2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30)</li></ol>	<ol style="list-style-type: none"><li>1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older.</li><li>2. Testing distance of 10 ft is recommended for all visual acuity tests.</li><li>3. A line of figures is preferred over single figures.</li><li>4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye.</li></ol>
<b>Ocular alignment:</b> <ul style="list-style-type: none"><li>◆ Unilateral cover test at 10 ft or 3 m or</li><li>◆ Random-dot-E stereo test at 40 cm (630 s of arc)</li></ul>	<p>Any eye movement</p> <p>&lt;4 of 6 correct</p>	

Source: Vision screening guidelines developed by the AAP Section on Ophthalmology Executive Committee, 1991-1992.  
*Pediatrics*, Vol. 98 No. 1, July 1996.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 59
		Date May 1, 2008

#### d. Hearing

The Joint Committee on Infant Hearing now recommends objective hearing screening for all neonates. See <http://www.jcih.org/posstatemts.htm>. Objective hearing screening performed on newborns and infants will detect congenial hearing loss, but will not identify those children with late onset hearing loss.

Objective hearing screening should be performed on all infants before age one month. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies.


Infants who do not pass the initial hearing screen and the subsequent rescreening should have appropriate audiology and medical evaluations to confirm the presence of hearing loss before 3 months. All infants with confirmed hearing loss should receive intervention services before 6 months of age.

For information on audiologists in your area see the early hearing detection and intervention system (EDHI) website, [www.idph.state.ia.us/iaehdi/default.asp](http://www.idph.state.ia.us/iaehdi/default.asp) or call 1-800-779-2001.

An objective hearing screening should be performed on all infants and toddlers who do not have a documented objective newborn hearing screening or documented parental refusal. For children up to age 3, each child should have an objective hearing screen or documented parent refusal.


A qualified screener should conduct objective hearing screening during well-child health screening appointments according to the periodicity schedule. In order to be alert to late onset hearing loss, health providers should also monitor developmental milestones, auditory and speech skills, middle ear status, and should consider parental concerns.

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss. The following are 11 risk indicators associated with either congenital or delayed-onset hearing loss. Heightened surveillance of all children with risk indicators is recommended. Risk indicators marked with an asterisk are greater concern for delayed onset hearing loss.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 60
		Date May 1, 2008

**Risk indicators** include:

1. Caregiver concern<sup>\*</sup> regarding hearing, speech, language, or developmental delay (Roizen, 1999).
2. Family history<sup>\*</sup> of permanent childhood hearing loss (Cone-Wesson et al., 2000; Morton & Nance, 2006).
3. Neonatal intensive care of more than 5 days or any of the following regardless of length of stay: ECMO,<sup>\*</sup> assisted ventilation, exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics (furosemide/lasix), and hyperbilirubinemia that requires exchange transfusion (Figor et al., 2005; Roizen, 2003).
4. In utero infections, such as CMV,<sup>\*</sup> herpes, rubella, syphilis, and toxoplasmosis (Fligor et al., 2005; Fowler et al., 1992; Madden et al., 2005; Nance et al., 2006; Pass et al., 2006 Rivera et al., 2002).
5. Craniofacial anomalies, including those involving the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies (Cone-Wesson et al., 2000).
6. Physical findings, such as white forelock, that are associated with a syndrome known to include a sensorineural or permanent conductive hearing loss (Cone-Wesson et al., 2000).
7. Syndromes associated with hearing loss or progressive or late-onset hearing loss,<sup>\*</sup> such as neurofibromatosis, osteopetrosis, and Usher syndrome (Roizen, 2003). Other frequently identified syndromes including Waardenburg, Alport, Pendred and Jervell and Lange-Nielson (Nance, 2003).
8. Neurodegenerative disorders,<sup>\*</sup> such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome (Roizen, 2003).
9. Culture-positive postnatal infections associated with sensorineural hearing loss,<sup>\*</sup> including confirmed bacterial and viral meningitis (especially herpes viruses and varicella) (Arditi et al., 1998; Bess, 1982; Biernath et al., 2006; Roizen, 2003).

 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	61 <hr/> Date May 1, 2008

10. Head trauma, especially basal skull/temporal bone fracture\* that requires hospitalization (Lew et al., 2004; Vartialnen et al., 1985; Zimmerman et al., 1993).
11. Chemotherapy\* (Bertolini et al., 22004).

For additional information on hearing screening, see *Hearing Screening Bright Futures, Guidelines for Health Supervision of Infants, Children and Adolescents*, Second Edition. <http://brightfutures.aap.org/web/>

## D. BASIS OF PAYMENT FOR RURAL HEALTH CLINIC SERVICES

Rural health clinics are reimbursed for services to Medicaid members based on 100 percent of the costs that are reasonable and related to the cost of furnishing clinic services.

Medicaid makes interim payments to the clinic until the clinic submits a cost report. The interim payments are based on a budgeted or projected average cost per visit and are subject to reconciliation after a cost report has been received.


Iowa Medicaid determines reasonable costs based on the clinic's cost report, submitted to the IME on the clinic's cost report form. The costs claimed in the approved cost report cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement principles.

### 1. Initial Cost Report

On receipt of the clinic's first cost report, Iowa Medicaid will compute the annual allowable Medicaid costs as reported by the clinic.

When the allowable reported annual Medicaid costs **exceed** the sum of the payments made to the clinic using the initial interim rate, Iowa Medicaid will make additional payment to the clinic. Payment adjustments will be made within 90 days of receipt of the cost report.

When the allowable reported payments are **less** than the sum of the payments made to the clinic using the initial interim rate, the clinic must reimburse Medicaid. Adjustments owed to Medicaid must be made within 90 days after Iowa Medicaid's notice to the clinic of the amount due.

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 62
		Date May 1, 2008

After the clinic submits a cost report that is accepted by Iowa Medicaid, the interim rate may be adjusted, if necessary, subject to reconciliation at the end of the cost reporting period.

## 2. Annual Cost Report

After receipt of the clinic's annual cost report, Iowa Medicaid will compute the annual allowable Medicaid costs as reported by the clinic.

When the allowable reported annual Medicaid costs **exceed** the sum of the payments made to the clinic under the interim rate for the cost-reporting period, Iowa Medicaid will make additional payment to the clinic. Payment adjustments will be made within 90 days of IME's receipt of the cost report.

When the allowable reported payments are **less** than the sum of the payments made to the clinic under the interim rate for the cost-reporting period, the clinic must reimburse Medicaid. Adjustments owed to Medicaid must be made within 90 days after Iowa Medicaid's notice to the clinic of the amount due.

After the clinic submits a cost report that is accepted by Iowa Medicaid, the interim rate may be adjusted, if necessary, subject to reconciliation at the end of the cost reporting period.

## 3. Form 470-3495, Managed Care Wraparound Payment Request

When a rural health clinic provides services under a contract with a managed care organization, the managed care organization is required to pay the clinic no less than the amount that the organization would pay for the services if furnished by a provider other than a rural health clinic.

In order to provide reasonable cost reimbursement as specified by Medicare cost reimbursement principles, the Department supplements the payment from the managed care organization by a direct payment to the clinic.

Clinics shall use form 470-3495, *Managed Care Wraparound Payment Request*, to document Medicaid visits and differences in payments by the managed care organization and the regular Medicaid visit payment for services that qualify for managed care wraparound payments (see [Other Services](#)). To view a sample of this form on line, click [here](#).

**Managed Care Wraparound Payment Request****Federally Qualified Health Centers, Rural Health Clinics**

Quarterly HMO Reconciliation Worksheet

(Due 30 days from end of previous quarter)

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 Name of Federally Qualified Health Center or Rural Health Clinic

 Return to: Iowa Medicaid Enterprise  
 Provider Cost Audit Unit  
 P.O. Box 36450  
 Des Moines, IA 50315  
 Fax: (515) 725-1353

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 Reconciliation Quarter Ending

1	2	3	4	5	6
# Medicaid HMO Encounters or Visits	Expected HMO Payments	Subcapitation Payments	Estimated HMO Payments to Be Received	Medicaid Regular Encounter or per Visit Payments	Difference Reimbursable to FQHC or RHC

- 1) Enter the number of daily encounters or visits for Medicaid members receiving HMO benefits. These encounters must follow the encounter rules as indicated in the Federally Qualified Health Center Provider Manual, Section VI, procedure codes and nomenclature, or rules for counting visits as indicated in the Rural Health Clinic Provider Manual, Section XX, procedure codes and billing.
- 2) List all dollar amounts normally expected to be received by the federally qualified health center or rural health clinic from the HMO for the services provided in #1. [Note: These amounts exclude any subcapitation arrangements to the federally qualified health center or rural health clinic.] If any payments are made over and above the general capitation payments, these must be included here.
- 3) List all dollar amounts of contractual, risk-based capitation payments made on behalf of the HMO (for Iowa Medicaid members) for the provision of care that is NOT separately reimbursed either by encounter, visit, or fee schedule.
- 4) Add together the total amounts from Columns 2 and 3.
- 5) Multiply the actual Medicaid encounter rate or per-visit interim rate times the number of encounters or visits reported in Column 1.
- 6) Subtract Column 5 from Column 4. This amount represents the wraparound payment that the Medicaid program will reimburse to the federally qualified health center or rural health clinic for the reconciliation quarter indicated.

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*I attest that this information is correct and complete to the best of my knowledge and that the calculations are supported by records maintained at our facility. Any adjustments or amendments to this report will be made within seven days of the original submission of this document.*

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 Signature

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 Date

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 Title of Submitter

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 63
		Date May 1, 2008

This form must be completed on a quarterly basis and submitted to the IME Provider Cost Audit and Rate-Setting Unit within 30 days after the end of the quarter. The Unit reviews the request and determines the proper supplemental (wraparound) payment to be made. Once this determination has been made, payment will be remitted to the clinic.

Instructions for completing form 470-3495 are as follows:


**Name of Federally Qualified Health Center or Rural Health Clinic:**

Indicate the name of the clinic.

**Reconciliation Quarter Ending:** Indicate the applicable reconciliation quarter.

1. **# Medicaid HMO Encounters or Visits:** Indicate in this space the number of daily visits for Iowa Medicaid members receiving HMO benefits. These visits must follow the rules for counting visits as indicated in [PROCEDURE CODES](#).
2. **Expected HMO Payments:** List all dollar amounts you normally expect to be received from the HMO for the services indicated in Item 1. NOTE: These amounts exclude any subcapitation arrangements between the clinic and the HMO. If any payments are made over and above the general capitation payments, these must be included here.
3. **Subcapitation Payments:** List all dollar amounts of contractual, risk-based capitation payments made on behalf of the HMO for Iowa Medicaid members, for the provision of care NOT separately reimbursed either by visit or by fee schedule.
4. **Estimated HMO Payments to Be Received:** Add together the expected HMO payments and subcapitation payments and enter the total estimated payments to be received from the HMO for the reconciliation quarter.
5. **Medicaid Regular Encounter or Per Visit Payments:** Multiply the actual Iowa Medicaid per-visit interim rate by the number of Medicaid HMO visits reported in Item 1 to calculate the Iowa Medicaid payments that would be received for the reconciliation quarter if the HMO visits were regular Medicaid visits.
6. **Difference Reimbursable to FQHC or RHC:** Subtract Item 5 from Item 4 to calculate the wraparound payment that Iowa Medicaid will reimburse to the clinic for the reconciliation quarter.



 Medicaid Enterprise Department of Human Services	Provider and Chapter	Page
	<b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	64 <hr/> Date May 1, 2008

**Attestation:** At the bottom of the form, the person completing the form must sign and enter the person's title and the date the form is signed.

## E. PROCEDURE CODES

Only one face-to-face visit between a member and a clinic health professional can be billed per day, even though the member may encounter the professional more than once or may encounter more than one professional.

An exception to this occurs when the member suffers illness or injury requiring additional diagnosis or treatment after the first visit on a particular day. In that situation, another visit is reimbursable. Refer those claims to the IME Provider Services Unit for special handling.

All rural health services billed on a given date must be submitted as one lump-sum charge under procedure code T1015, rural health visit. In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. The applicable modifiers are:

<u>Modifier</u>	<u>Description</u>
EP	Services provided because of the findings from a Care for Kids (EPSDT) screening examination.
FP	Service related to family planning.
U1	Care for Kids (EPSDT) screen with referral for treatment.
U3	Medical expense services, e.g., those related to mental health diagnoses not covered by the Iowa Plan for Behavioral Health (Iowa Plan).
U6	Care for Kids (EPSDT) screen.
32	Annual routine physical required for an RCF resident.

## F. CMS-1500 CLAIM FORM

Claims for rural health clinic visits shall be submitted on the CMS-1500 claim form. To view a sample of this form on line, click [here](#).

### 1. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the CMS-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																																																	
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY										STATE										CITY										STATE																													
ZIP CODE										TELEPHONE (Include Area Code) ( )										ZIP CODE										TELEPHONE (Include Area Code) ( )																													
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE										11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME																													
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																																																	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER																																																	
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																																											
1																				NPI																																							
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5																				NPI																																							
6																				NPI																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____										33. BILLING PROVIDER INFO & PH # ( ) a. NPI b. _____																																							

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

#### **REFERS TO GOVERNMENT PROGRAMS ONLY**

**MEDICARE AND CHAMPUS PAYMENTS:** A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

#### **BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

#### **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

**NOTICE:** Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

#### **NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S):** To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

**ROUTINE USE(S):** Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

**DISCLOSURES:** Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

#### **MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

**NOTICE:** This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.



For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	<b>REQUIRED.</b> Check the applicable program block.
1a.	INSURED'S ID NUMBER	<b>REQUIRED.</b> Enter the Medicaid member's Medicaid number, found on the <i>Medical Assistance Eligibility Card</i> . The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A.  Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	<b>REQUIRED.</b> Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	<b>OPTIONAL.</b> Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient. For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	<b>OPTIONAL.</b> Enter the address and phone number of the patient, if available.
6.	PATIENT RELATIONSHIP TO INSURED	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	<b>REQUIRED, IF KNOWN.</b> Check boxes corresponding to the patient's current marital and occupational status.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
9a-d.	OTHER INSURED'S NAME	<b>SITUATIONAL.</b> Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.
10.	IS PATIENT'S CONDITION RELATED TO	<b>REQUIRED, IF KNOWN.</b> Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	<b>OPTIONAL.</b> No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	<b>OPTIONAL.</b> For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	<b>REQUIRED.</b> If the Medicaid member has other insurance, check "yes" and enter the payment amount in field 29. If "yes," then boxes 9a-9d must be completed.  If there is no other insurance, check "no."  If you have received a denial of payment from another insurance, check <b>both</b> "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record.  Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.  NOTE: Auditing will be performed on a random basis to ensure correct billing.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL.</b> No entry required.
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	<b>OPTIONAL.</b> No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY, PREGNANCY	<b>SITUATIONAL.</b> Enter the date of the onset of treatment as month, day, and year. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	<b>SITUATIONAL.</b> Chiropractors must enter the current X-ray as month, day, and year. For all others, no entry is required.
16.	DATES PATIENT UNABLE TO WORK...	<b>OPTIONAL.</b> No entry required.
17.	NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	<b>CONDITIONAL.</b> Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the health care provider that directed the patient to your office.
17a.		<b>OPTIONAL.</b> No entry required.
17b.	NPI	<b>SITUATIONAL.</b> If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit national provider identifier (NPI) of the referring provider.  If this claim is for consultation, independent lab, or DME, enter the NPI of the referring or prescribing provider.  If the patient is on lock-in and the lock-in provider authorized the service, enter that provider's NPI.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
18.	HOSPITALIZATION DATES RELATED TO...	<b>OPTIONAL.</b> No entry required.
19.	RESERVED FOR LOCAL USE	<b>OPTIONAL.</b> No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box, "Y – Pregnant."
20.	OUTSIDE LAB	<b>OPTIONAL.</b> No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	<b>REQUIRED.</b> Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary, 2-secondary, 3-tertiary, and 4-quaternary), to a maximum of four diagnoses.  If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows:  640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	<b>SITUATIONAL.</b> If there is a prior authorization, enter the prior authorization number. Obtain this number from the prior authorization form.
24. A	DATE(S) OF SERVICE	<b>REQUIRED.</b> Enter month, day, and year under both the "From" and "To" columns for each procedure, service, or supply.  If the "From-To" dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a monthly basis, spanning or overlapping billing months could cause the entire claim to be denied.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	<p><b>REQUIRED.</b> Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.</p> <ul style="list-style-type: none"><li>11 Office</li><li>12 Home</li><li>21 Inpatient hospital</li><li>22 Outpatient hospital</li><li>23 Emergency room – hospital</li><li>24 Ambulatory surgical center</li><li>25 Birthing center</li><li>26 Military treatment facility</li><li>31 Skilled nursing</li><li>32 Nursing facility</li><li>33 Custodial care facility</li><li>34 Hospice</li><li>41 Ambulance – land</li><li>42 Ambulance – air or water</li><li>51 Inpatient psychiatric facility</li><li>52 Psychiatric facility – partial hospitalization</li><li>53 Community mental health center</li><li>54 Intermediate care facility/mentally retarded</li><li>55 Residential substance abuse treatment facility</li><li>56 Psychiatric residential treatment center</li><li>61 Comprehensive inpatient rehabilitation facility</li><li>62 Comprehensive outpatient rehabilitation facility</li><li>65 End-stage renal disease treatment</li><li>71 State or local public health clinic</li><li>72 Rural health clinic</li><li>81 Independent laboratory</li><li>99 Other unlisted facility</li></ul>
24. C	EMG	<p><b>OPTIONAL.</b> No entry required.</p>





FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
24. D	PROCEDURES, SERVICES OR SUPPLIES	<b>REQUIRED.</b> Enter the codes for each of the dates of service. <b>Do not</b> list services for which no fees were charged.  Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show the HCPCS code modifiers with the HCPCS code.
24. E	DIAGNOSIS POINTER	<b>REQUIRED.</b> Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. <b>Do not</b> write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	\$ CHARGES	<b>REQUIRED.</b> Enter the usual and customary charge for each line item. This is defined as the provider's customary charges to the public for the services.
24. G	DAYS OR UNITS	<b>REQUIRED.</b> Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	<b>SITUATIONAL.</b> Enter "F" if the service on this claim line is for family planning. Enter "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	<b>OPTIONAL.</b> No entry required.
24. J	RENDERING PROVIDER ID #	<b>SITUATIONAL.</b> The "rendering provider" is the practitioner who provided, supervised, or ordered the service. In the lower portion, enter the NPI of the provider rendering the service when the NPI given in field 33 is that of a group or is not that of the treating provider.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
25.	FEDERAL TAX ID NUMBER	<b>OPTIONAL.</b> No entry required.
26.	PATIENT'S ACCOUNT NUMBER	<b>FOR PROVIDER USE.</b> Enter the account number you have assigned to the patient. This field is limited to 10 alphabetical or numeric characters.
27.	ACCEPT ASSIGNMENT?	<b>OPTIONAL.</b> No entry required.
28.	TOTAL CLAIM CHARGE	<b>REQUIRED.</b> Enter the total of the line-item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form.
29.	AMOUNT PAID	<b>SITUATIONAL.</b> Enter only the amount paid by other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	<b>REQUIRED.</b> Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	<b>REQUIRED.</b> Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form.  If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	<b>REQUIRED.</b> Enter the name and address associated with the rendering provider.
32a.	NPI	<b>OPTIONAL.</b> Enter the NPI of the facility where services were rendered.



FIELD NUMBER	FIELD NAME/ DESCRIPTION	INSTRUCTIONS
32b.		<b>OPTIONAL.</b> No entry required.
33.	BILLING PROVIDER INFO AND PHONE #	<b>REQUIRED.</b> Enter the complete name and address of the billing provider or service provider. The "billing provider" is defined as the provider that is requesting to be paid for the services rendered.  NOTE: The ZIP code must match the ZIP code confirmed during NPI verification or during enrollment. To view the ZIP code provided, access <a href="http://imeservices.org">imeservices.org</a> .
33a.	NPI	<b>REQUIRED.</b> Enter the ten-digit NPI of the billing provider.  A provider that does not meet the definition of "health care provider" and therefore does not meet the criteria to receive an NPI should enter the ten-digit provider number assigned by IME (begins with "X00"). If this number identifies a group or an individual provider other than the provider of service, the rendering provider's NPI must be entered in field 24J for each line.  NOTE: The NPI must match the NPI confirmed during NPI verification or during enrollment. To view the NPI provided, access <a href="http://imeservices.org">imeservices.org</a> .
33b.		<b>REQUIRED.</b> Enter qualifier "ZZ" followed by the taxonomy code of the billing provider. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification or during enrollment. To view the taxonomy code provided, access <a href="http://imeservices.org">imeservices.org</a> .

## 2. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- ◆ **Complete** form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click [here](#). Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number.

**Iowa Medicaid Program**

## Claim Attachment Control

Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.

**Attachment Control Number**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**Provider Name** \_\_\_\_\_

**NPI Billing Provider Number**

--	--	--	--	--	--	--	--	--	--

**Member Name** \_\_\_\_\_

**Member State ID Number**

--	--	--	--	--	--	--	--

**Date of Service** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Type of Document**


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**Return this document with attachments to:**

IME Claims  
P.O. Box 150001  
Des Moines, IA 50315

 Medicaid Enterprise Department of Human Services	Provider and Chapter <b>Rural Health Clinic</b> Chapter III. Provider-Specific Policies	Page 73
		Date May 1, 2008

If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

- ◆ **Staple** the additional information to the *Claim Attachment Control*. Do **not** attach a paper claim.
- ◆ **Mail** the *Claim Attachment Control* with attachments to:

Iowa Medicaid Enterprise  
 PO Box 150001  
 Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

## G. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

### 1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims.

- ◆ **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- ◆ **Denied** represents all processed claims for which no reimbursement is made.
- ◆ **Suspended** reflects claims that are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print, depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- ◆ Print suspended claims only once.
- ◆ Print all suspended claims until paid or denied.
- ◆ Do not print suspended claims.



Note that claim credits or recoupments (reversed) appear as regular claims, with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

## 2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click [here](#).

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	<i>Remittance Advice</i> page number.

IAMC8000-R001 (CP-O-12)  
AS OF 10/22/07

IOWA DEPARTMENT OF HUMAN SERVICES  
MEDICAID MANAGEMENT INFORMATION SYSTEM

RUN DATE 10/19/07

R E M I T T A N C E   A D V I C E

4

TO: 1

R.A. NO.: 3 2 6

WARR NO.: 9 3 9

DATE PAID: 10/22/07 PROV. NUMBER: 5

PAGE: 6 1

**** PATIENT NAME ****	RECIP ID /	TRANS-CONTROL-NUMBER /	BILLED	OTHER	PAID BY	COPAY	MED RCD NUM /						
LAST	FIRST MI	LINE	SVC-DATE	PROC/MODS	UNITS	AMT.	SOURCES	MCAID	AMT.	PERF. PROV.	S	EOB	EOB

\* \* \* CLAIM TYPE: HCFA 1500 7

\* \* \* CLAIM STATUS: PAID 8

ORIGINAL CLAIMS:

9	10	11	12	13	14	15	16	17
3-07290-00-015-0941-00	21	172.00	0.00	85.07	1.00	000 000		
01 10/04/07 99242 20	1	172.00	22	23	24	25	26	27
3-07292-00-009-0053-00	69.00	0.00	32.36	0.00	000 000			
01 07/06/07 99212	1	69.00	32.36	0.00	F 000 000			
3-07288-00-010-0484-00	298.00	0.00	145.03	0.00	000 000			
01 07/11/07 99212 25	1	69.00	32.36	0.00	F 000 000			
02 07/11/07 29405	1	197.00	112.67	0.00	F 000 000			
03 07/11/07 A4590	1	32.00	0.00	0.00	K 177 000			
0-07281-22-009-0270-00	128.00	0.00	71.46	0.00	000 000			
01 06/14/07 20550	1	122.00	68.06	0.00	F 000 000			
02 06/14/07 J3301	2	6.00	3.40	0.00	F 000 000			
4 CLAIMS - THIS CLAIM TYPE / THIS CLAIM STATUS. TOTALS..	667.00	0.00	333.92	1.00				



NO.	FIELD NAME	DESCRIPTION
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: <ul style="list-style-type: none"><li>• <b>Paid.</b> Claims for which reimbursement is being made.</li><li>• <b>Denied.</b> Claims for which no reimbursement is being made.</li><li>• <b>Suspended.</b> Claims in process. These claims have not yet been paid or denied.</li></ul>
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the <i>Remittance Advice</i> for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.





NO.	FIELD NAME	DESCRIPTION
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: <b>B</b> Billed charge <b>F</b> Fee schedule <b>M</b> Manually priced <b>N</b> Provider charge rate <b>P</b> Group therapy <b>Q</b> EPSDT total screen over 17 years <b>R</b> EPSDT total under 18 years <b>S</b> EPSDT partial over 17 years <b>T</b> EPSDT partial under 18 years <b>U</b> Gynecology fee <b>V</b> Obstetrics fee <b>W</b> Child fee
28.	Remittance totals	(Found at the end of the <i>Remittance Advice</i> ): <ul style="list-style-type: none"><li>• Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid.</li><li>• Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid.</li><li>• Number of denied original claims and the amount billed by the provider.</li><li>• Number of denied adjusted claims and the amount billed by the provider.</li><li>• Number of pended claims (in process) and the amount billed by the provider.</li><li>• Amount of the check (warrant) written to pay these claims.</li></ul>
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.